

Veterans Medical Care: FY2010 Appropriations

Updated January 21, 2010

Congressional Research Service

<https://crsreports.congress.gov>

R40737

Summary

The Department of Veterans Affairs (VA) provides benefits to veterans who meet certain eligibility criteria. Benefits to veterans range from disability compensation and pensions to hospital and medical care. The VA provides these benefits through three major operating units: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA).

This report focuses on the VHA. The VHA is primarily a direct service provider of primary care, specialized care, and related medical and social support services to veterans through the nation's largest integrated health care system. Veterans generally must enroll in the VA health care system to receive medical care. Eligibility for enrollment is based primarily on previous military service, disability, and income. VA provides free inpatient and outpatient medical care to veterans for service-connected conditions and to low-income veterans for nonservice-connected conditions.

On February 26, 2009, the President submitted a preliminary budget outline for FY2010, and submitted his full FY2010 budget proposal to Congress on May 7. The Administration requested a total of \$45.1 billion for VHA (excluding collections). This is a 7.5% increase over the FY2009 enacted level. Including total available resources (including medical care collections), the President's budget would provide approximately \$48 billion for VHA.

Based on the President's preliminary budget outline, on April 29, 2009, the House and Senate agreed to the conference report to accompany the FY2010 budget resolution (S.Con.Res. 13, H.Rept. 111-89). The conference agreement provides \$53.4 billion in discretionary budget authority and \$53.1 billion in mandatory budget authority for VA programs. Sections 402 and 424 of the conference agreement included language exempting the medical services, medical support and compliance, and medical facilities accounts from a point of order against advance appropriations. Furthermore, the conference agreement states that VHA is not and should not be authorized to bill private insurance companies for treatment of health conditions that are related to veterans' service-connected disabilities.

On July 10, the House passed its version of the Military Construction and Veterans Affairs Appropriations Act, 2010 (H.R. 3082, H.Rept. 111-188). The House-passed bill provided a total of \$45.1 billion for VHA. H.R. 3082 also provided \$48.2 billion in advance appropriations for VHA to be available in FY2011. On November 17, the Senate passed H.R. 3082 as amended. H.R. 3082 as amended by the Senate provided a total of \$45.2 billion for VHA, a \$160.0 million increase over the House-passed amount, and \$157.6 million over the President's request.

The Consolidated Appropriations Act was signed into law on December 16, 2009 (P.L. 111-117, H.Rept. 111-366). Division E of the Consolidated Appropriations Act 2010 included a compromised version of the House and Senate passed versions of Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2010. The Consolidated Appropriations Act provides a total of \$45.1 billion for VHA, same as the Administration's request for FY2010, and 7.4% over the FY2009 enacted amount. P.L. 111-117 includes an advance appropriation of \$48.2 billion for the medical services, medical support and compliance, and medical facilities accounts to be available in FY2011.

With the enactment of the Consolidated Appropriations Act, 2010 (P.L. 111-117), the FY2010 appropriations process for VHA was completed by Congress. This report will not be updated.

Contents

Most Recent Developments.....	1
Introduction	4
The Veterans Health Care System	5
Training of Health Care Professionals	9
The Veteran Patient Population	11
Eligibility for Veterans Health Care	13
“The Promise of Free Health Care”	13
VHA Health Care Enrollment	14
Veteran’s Status.....	15
Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans	16
Medical Benefits Package	16
Priority Groups and Scheduling Appointments	17
Formulation of VHA’s Budget.....	17
Funding for the VHA.....	18
Medical Services	19
Medical Support and Compliance (Previously Medical Administration)	19
Medical Facilities	19
Medical and Prosthetic Research	19
Medical Care Collections Fund (MCCF)	19
Consolidated Patient Accounting Centers (CPACs).....	20
FY2009 Budget Summary	22
House Action	22
Senate Committee Action.....	23
Final MILCON-VA Appropriations Act of 2009.....	23
American Recovery and Reinvestment Act (P.L. 111-5) Funds.....	23
FY2010 VHA Budget	23
President’s Request	23
FY2010 Congress Congressional Budget Resolution	24
House Action	24
Senate Action	25
Final MILCON-VA Appropriations Act, 2010	26
Major Issues	26
Advance Appropriations.....	26
Priority Group 8 Veterans.....	27
Beneficiary Travel Mileage Reimbursement.....	29

Figures

Figure 1. Enacted Appropriations for VHA, FY1995-FY2009	2
Figure 2. FY2009 VA Budget Allocations	5
Figure 3. Veterans Integrated Services Networks (VISNs)	7
Figure 4. VA Health Professionals Training Program: Percent Distribution of Program Participants, FY2008	11

Tables

Table 1. VA Appropriations, FY2009-FY2010, and Advance Appropriations, FY2011	3
Table 2. FY2009 VERA Allocations	8
Table 3. Number of Veterans Enrolled in the VA Health Care System, FY2006-FY2010	12
Table 4. Number of Patients Receiving Care from the VA, FY2006-FY2010	12
Table 5. Medical Care Collections, FY2003-FY2008	21
Table 6. Enrollment and Expenditures for FY2009- Under Current Policy and Under Expanded Enrollment Policy	28
Table 7. VHA Appropriations by Account, FY2009-FY2010 and Advance Appropriations, FY2011	32
Table A-1. VA Priority Groups and Their Eligibility Criteria	34
Table B-1. Copayments for Health Care Services: 2010	36

Appendixes

Appendix A. VA Priority Groups and Their Eligibility Criteria	34
Appendix B. Copayments for Health Care Services: 2010	36
Appendix C. Financial Income Thresholds for VA Health Care Benefits, Calendar Year 2010	38
Appendix D. 10% Increase to Financial Income Thresholds for VA Health Care Enrollment, in Priority Group 8, Calendar Year 2010	39

Contacts

Author Information	40
--------------------------	----

Most Recent Developments

On December 10, 2009, the House adopted the conference report (H.Rept. 111-366) to accompany the Department of Transportation, Housing and Urban Development appropriations Act, 2010, and retitled as the Consolidated Appropriations Act 2010 (H.R. 3288). The Senate adopted the conference report on December 13, 2009. Division E of the Consolidated Appropriations Act 2010 included a compromise version of the House- and Senate-passed versions of Military Construction and Veterans Affairs and Related Agencies Appropriations Act 2010 (MILCON-VA Appropriations Act of 2010). The Consolidated Appropriations Act was signed into law on December 16, 2009 (P.L. 111-117).¹

The MILCON-VA Appropriations Act, 2010, provides a total of approximately \$45.1 billion for the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA). This is a 7.4% increase over the FY2009 enacted amount and the same as the Administration's budget request for VHA (see **Table 1**).² This amount includes funding for the medical services (\$34.7 billion), medical support and compliance (\$4.9 billion), medical facilities (\$4.9 billion), and medical and prosthetic research (\$581.0 million) accounts. The Consolidated Appropriations Act (P.L. 111-117) also provides approximately \$48.2 billion in advance appropriations for the medical services, medical support and compliance, and medical facilities accounts to be available in FY2011.

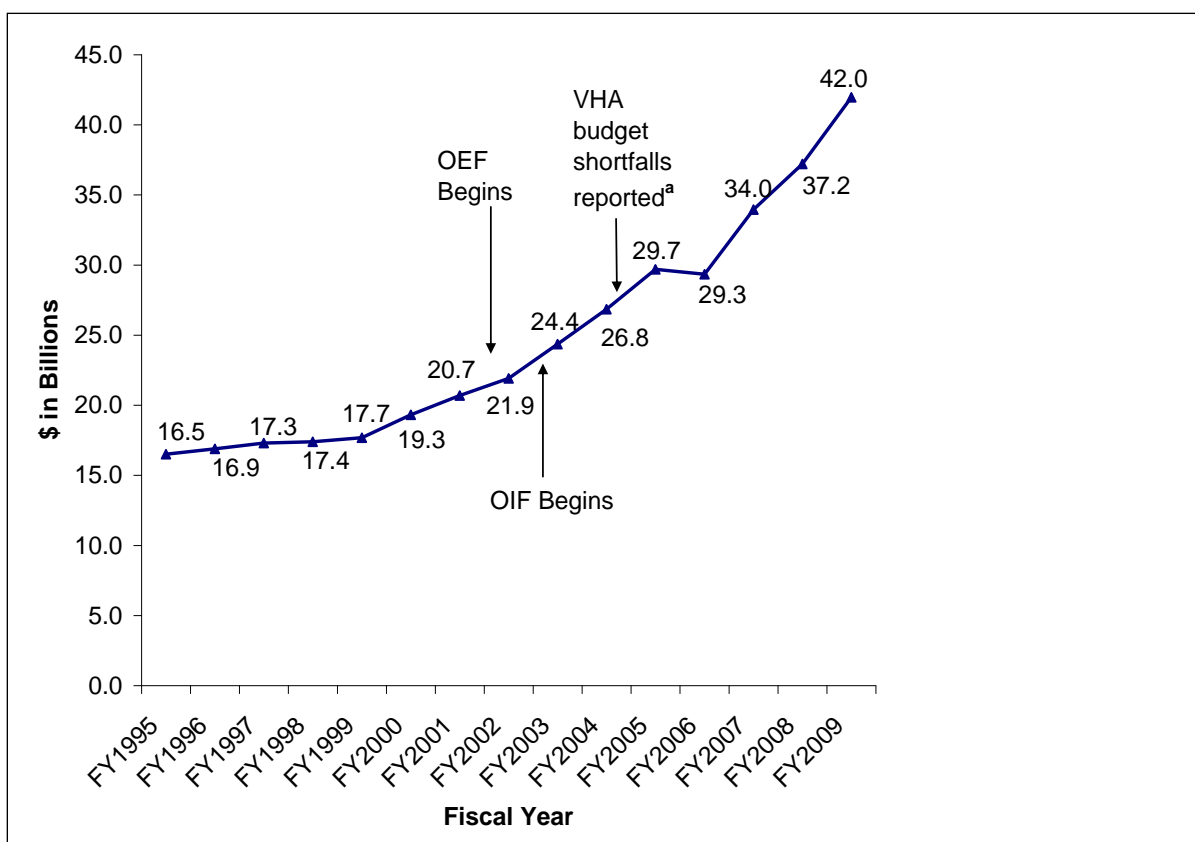
As seen in **Figure 1**, funding for VHA has seen significant growth between FY1995 and FY2009. During this time period funding for VHA increased by 154%, while the average *annual* increase was 6.9%. From FY1995 to FY2005 the average *annual* increase was 6.7% whereas average *annual* increase between FY2006 and FY2009 was 12.7% (**Figure 1**). The growth in funding could be attributed to aging of many World War II and Korean War veterans with a greater need for health care services, veterans' increasing reliance on VHA's pharmaceutical benefits,³ and more recent veterans from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) accessing the VA health care system. Veterans from OEF and OIF account for a rising proportion of VA's total patient work load. In FY2010 OEF and OIF patients will represent about 7% of the overall VA patient population, compared to about 3% in FY2006.⁴

¹ Among other appropriation bills, the conference agreement included the Commerce, Justice, Science, and Related Agencies Appropriations Act, 2010; the Financial Services and General Government Appropriations Act, 2010; the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2010; and the Department of State, Foreign Operations, and Related Programs Appropriations Act, 2010.

² The FY2009 enacted amount includes supplemental funding provided by the American Recovery and Reinvestment Act (P.L. 111-5).

³ Department of Veterans Affairs, *FY2010 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4, May 2009, p. 1C-3.

⁴ Ibid. p. 1I-21, and U.S. Congress, House Committee on Veterans' Affairs, *The Status of the Department of Veterans Affairs*, 111th Cong., 1st sess., February 4, 2009 (Washington: GPO, 2009), p. 49.

Figure I. Enacted Appropriations for VHA, FY1995-FY2009

Source: Congressional Research Service, based on House and Senate Appropriations Committee reports accompanying the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriation Acts and Military Construction and Veterans Affairs Appropriations Acts.

Notes: OEF= Operation Enduring Freedom. OEF commenced in October 2001, and includes operations in and around Afghanistan as well as Guantanamo Bay (Cuba), Djibouti, Eritrea, Ethiopia, Jordan, Kenya, Kyrgyzstan, Philippines, Seychelles, Sudan, Tajikistan, Turkey, and Yemen.

OIF= Operation Iraqi Freedom. OIF commenced in March 2003, and includes operations in Iraq and in the Arabian Sea, Bahrain, Gulf of Aden, Gulf of Oman, Iraq, Kuwait, Oman, Persian Gulf, Qatar, Red Sea, Saudi Arabia, and United Arab Emirates.

Enacted figures include medical services, medical support and compliance (previously medical administration), medical facilities, and medical and prosthetic research accounts. The figures exclude collections deposited into the medical care collections fund (MCCF).

a. In June 2005, the Administration requested additional funds from Congress for FY2005 (a \$975 million supplemental appropriation) and in July 2005, the Administration requested additional funds for FY2006 (a budget amendment of \$1.977 billion). For details see CRS Report RL33409, *Veterans' Medical Care: FY2007 Appropriations*, by Sidath Viranga Panangala.

The remainder of this report is organized as follows. The first section of the report provides an overview of the Department of Veterans Affairs (VA) health care system. The second section provides a description of the veteran patient population and eligibility for VA health care. The third section provides a brief overview of the FY2009 Veterans Health Administration (VHA) budget. The fourth section discusses the FY2010 VHA budget including House and Senate action. Lastly, the report discusses major VA health care issues as they pertain to the FY2010 budget.

Table I.VA Appropriations, FY2009-FY2010, and Advance Appropriations, FY2011

(\$ in thousands)

	FY2009 Enacted	FY2010 Request	House (H.R. 3082)		Senate (H.R. 3082)		Enacted (P.L. 111-117)	
			FY2010	FY2011	FY2010	FY2011	FY2010	FY2011
Total Department of Veterans Affairs (VA)	\$95,948,057	\$108,860,775	\$108,859,775	—	\$109,060,409	—	\$109,607,626	—
Total Mandatory	46,742,925	55,821,672	55,821,672	—	55,821,672	—	56,568,316	—
Total Discretionary	49,205,132	53,039,103	53,038,103	—	53,238,737	—	53,039,310	—
Total Veterans Health Administration (VHA) ^a	\$41,958,903	\$45,077,500	\$45,075,000	—	\$45,235,133	—	\$45,077,500	—
Memorandum: Advance appropriations VHA ^b	—	—	—	\$48,183,000	—	\$48,183,000	—	\$48,183,000

Sources: *Congressional Record*, vol.154, (September 24, 2008), pp. H9868-H9869, H.Rept. 111-188, S.Rept. 111-40, *Congressional Record*, vol.155, (July 10, 2009), pp. H7983-H7987, *Congressional Record*, vol.171, (November 18, 2009), pp. S11503-S11508, and Division E of H.Rept. 111-366.

Notes: FY2009 enacted includes funding provided in the American Recovery and Reinvestment Act of 2009 (P.L. 111-5).

- a. Includes funding for medical services, medical support and compliance, medical facilities, and medical and prosthetic research accounts, and excludes collections deposited into the Medical Care Collections Fund (MCCF).
- b. The House and Senate Military Construction and Veterans Affairs Appropriations bills for FY 2010, and Division E of the Consolidated Appropriations Act 2010 (Military Construction and Veterans Affairs Appropriations Act, 2010) provided budget authority for FY2011 for the following accounts: medical services, medical support and compliance, and medical facilities. Under current budget scoring guidelines new budget authority for an advance appropriation is scored in the fiscal year in which the funds become available for obligation. Therefore, in this table the budget authority is recorded in the FY2011 column.

Introduction

The history of the present day Department of Veterans Affairs (VA) can be traced back to July 21, 1930, when President Hoover issued Executive Order 5398 consolidating separate veterans' programs and creating an independent federal agency known as the Veterans Administration.⁵ On October 25, 1988, President Reagan signed legislation (P.L. 100-527) creating a new federal cabinet-level Department of Veterans Affairs to replace the Veterans Administration effective March 15, 1989.

The VA provides a range of benefits and services to veterans who meet certain eligibility rules including hospital and medical care, disability compensation and pensions,⁶ education,⁷ vocational rehabilitation and employment services, assistance to homeless veterans,⁸ home loan guarantees,⁹ administration of life insurance as well as traumatic injury protection insurance for servicemembers, and death benefits that cover burial expenses.

The Department carries out its programs nationwide through three administrations and the Board of Veterans Appeals (BVA). The Veterans Health Administration (VHA) is responsible for health care services and medical and prosthetic research programs. The Veterans Benefits Administration (VBA) is responsible for, among other things, providing compensations, pensions, and education assistance. The National Cemetery Administration (NCA)¹⁰ is responsible for maintaining national veterans cemeteries; providing grants to states for establishing, expanding, or improving state veterans cemeteries; and providing headstones and markers for the graves of eligible persons, among other things.

The VA's budget includes both mandatory and discretionary spending accounts. Mandatory funding supports disability compensation, pension benefits, education, vocational rehabilitation, and life insurance, among other benefits and services. Discretionary funding supports a broad array of benefits and services including medical care. **Figure 2** provides a breakdown of FY2009 budget allocations for both mandatory and discretionary programs. In FY2009 the total VA budget authority was approximately \$96 billion; discretionary budget authority accounted for about 51.2% (\$49.2 billion) of the total, with about 85% of this discretionary funding going toward supporting VA health care programs.

⁵ In the 1920s three federal agencies, the Veterans Bureau, Bureau of Pensions in the Department of the Interior, and the National Home for Disabled Volunteer Soldiers administered various benefits for the nation's veterans.

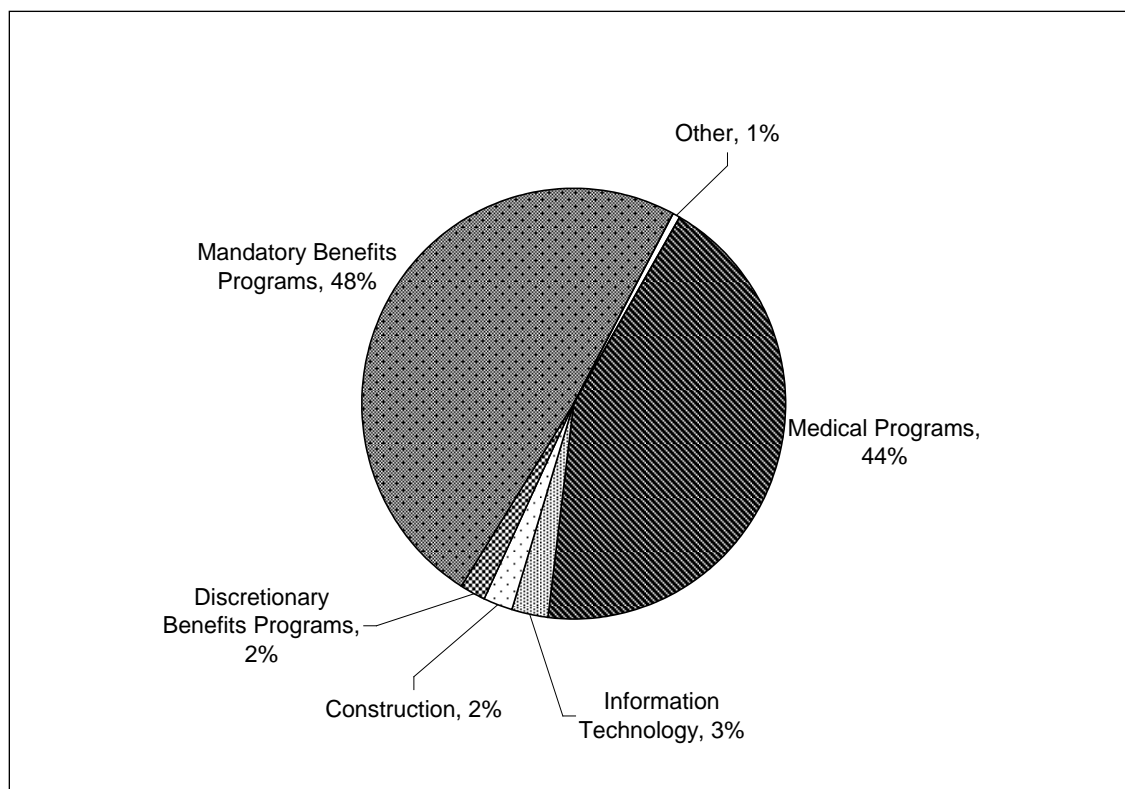
⁶ For detailed information on disability compensation and pension programs see CRS Report RL33323, *Veterans Affairs: Benefits for Service-Connected Disabilities*, by Douglas Reid Weimer, and CRS Report RS22804, *Veterans' Benefits: Pension Benefit Programs*, by Christine Scott and Carol D. Davis.

⁷ For details on education benefits see CRS Report R40723, *Educational Assistance Programs Administered by the U.S. Department of Veterans Affairs*, by Cassandra Dortch.

⁸ For detailed information on homeless veterans programs see CRS Report RL34024, *Veterans and Homelessness*, by Libby Perl.

⁹ For details on the home loan guarantee program see CRS Report RS20533, *VA-Home Loan Guaranty Program: An Overview*, by Bruce E. Foote.

¹⁰ Established by the National Cemeteries Act of 1973 (P.L. 93-43).

Figure 2. FY2009 VA Budget Allocations

Source: Chart prepared by Congressional Research Service based on figures contained in *Congressional Record*, vol. 154, (September 24, 2008), pp. H9868-H9869 and P.L. 111-5.

The Veterans Health Care System

The VHA operates the nation's largest integrated direct health care delivery system.¹¹ While Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP) are also publicly funded programs, most health care services under these programs are delivered by private providers in private facilities. In contrast, the VA health care system is a truly public health care system in the sense that the federal government owns the medical facilities and employs the health care providers.¹²

The VA's health care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs) (see **Figure 3**). Although policies and guidelines are developed at VA headquarters to be applied throughout the VA health care system, management authority for basic decision making and budgetary responsibilities are delegated to the VISNs.¹³ Congressionally appropriated medical care funds are allocated to the VISNs based on the Veterans Equitable Resource Allocation (VERA) system, which generally bases funding on patient workload. VISNs, in turn, allocate funds to the medical centers within their networks. Prior to the implementation of

¹¹ Established on January 3, 1946 as the Department of Medicine and Surgery by P.L. 79-293, succeeded in 1989 by the Veterans Health Services and Research Administration, renamed the Veterans Health Administration in 1991.

¹² U.S. Congress, House, *Economic Report of the President*, 110th Cong., 2nd sess., February 2008, H. Doc. 110-83 (Washington: GPO, 2008), p. 106.

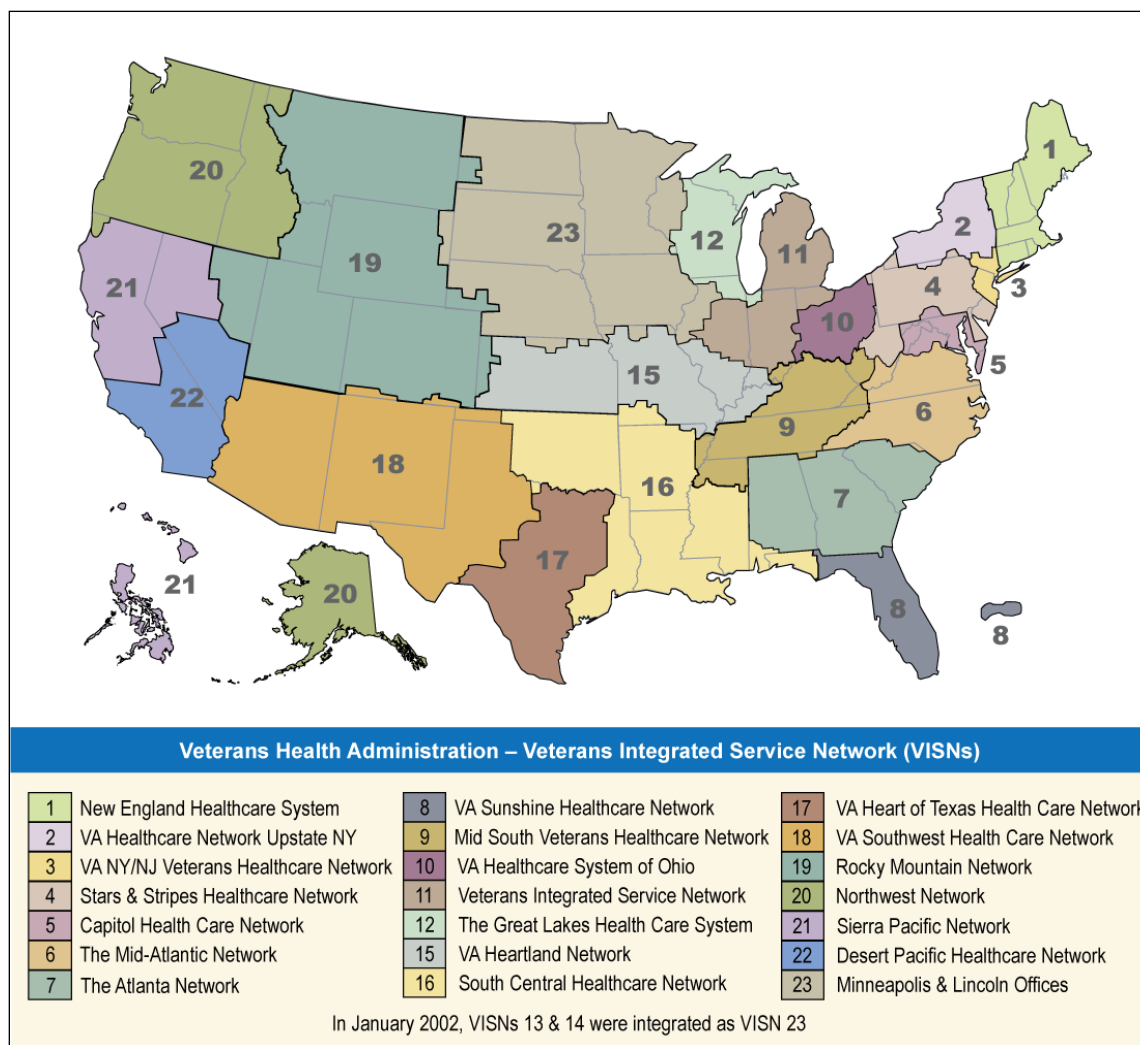
¹³ Kizer Kenneth, John Demakis, and John Feussner, "Reinventing VA health care: Systematizing Quality Improvement and Quality Innovation." *Medical Care*. vol. 38, no. 6 (June 2000), Suppl 1:17-16.

the VERA system, resources were allocated to facilities based primarily on their historical expenditures. While a thorough description of VERA is beyond the scope of this report, generally VERA has two types of funds known as General Purpose funds and Specific Purpose funds.

General Purpose funds encompass about 83.5% of VHA total budget allocations to the VISNs. General Purpose funds are distributed to the 21 VISNs at the beginning of each fiscal year and are comprised of 8 elements. These elements include basic care, complex care, adjustments for high cost patients, geographic price adjustment, research support, education support, equipment, and non-recurring maintenance.

The Specific Purpose funds are given to the 21 VISNs during the year for specific activities including prosthetics, mental health, homeless grants and per diem program, state home per diems, transplants, clinical trainees, readjustment counseling, and medical facility activations. Under VERA each network is provided an allocation that takes into account its unique characteristics, and that is also adjusted to account for those veterans who receive care in more than one network.

As seen in **Table 2** the largest allocations of funds in FY2009 were to VISNs: **8** (Florida and Puerto Rico), **16** (Mississippi, Arkansas, Louisiana, Oklahoma, some parts of Texas), **22** (some parts of California and Nevada), **7** (Alabama, Georgia, and South Carolina), and **21** (some parts of California, and Nevada, Hawaii and Philippines). While VISNs **8**, **16**, **7**, and **4** have the greatest number of unique veteran patients, VERA funding is not driven by veteran patient population alone, but is adjusted for differences in patient mix, high cost patients, and geographic costs, among other factors.

Figure 3. Veterans Integrated Services Networks (VISNs)

Source: Department of Veterans Affairs, adapted by Congressional Research Service.

Table 2. FY2009 VERA Allocations

(\$ in thousands)

Network (VISN)	Basic Care ^a	Complex Care ^a	High Cost Patient Allocations ^a	Geographic Price Adjustment ^a	Research Support ^a	Education Support ^a	Equipment ^a	Non- recurring Maintenance ^a	4% Floor Adjustment ^a	Total General Purpose Allocation ^a
1	\$859,369	\$269,467	\$171,151	\$59,786	\$42,627	\$36,258	\$62,795	\$40,002	\$(1,777)	\$1,539,678
2	480,484	165,529	57,603	(19,845)	3,743	16,618	35,046	21,148	10,022	770,348
3	698,879	247,079	246,858	86,247	15,077	41,343	50,610	44,205	8,266	1,438,564
4	1,033,231	308,041	143,951	(22,640)	18,989	20,880	81,067	48,689	870	1,633,078
5	469,096	194,628	89,646	18,284	17,584	17,641	34,043	18,231	7,030	866,183
6	1,085,729	316,845	138,101	(31,222)	14,501	27,042	74,449	32,886	(2,840)	1,655,491
7	1,170,695	367,968	122,428	(47,506)	22,493	32,816	84,484	37,598	(2,466)	1,788,510
8	1,989,487	465,785	193,712	(109,744)	14,964	45,612	136,947	67,680	(2,917)	2,801,526
9	1,020,301	250,836	93,251	(51,743)	15,756	38,654	69,364	34,225	(1,894)	1,468,750
10	754,083	351,823	77,069	(17,389)	13,730	19,823	52,640	31,482	(1,558)	1,281,703
11	874,204	230,499	101,074	(20,464)	17,753	23,163	63,089	38,810	(1,838)	1,326,290
12 ^b	849,628	285,821	136,380	34,013	21,315	45,354	61,768	41,908	(1,612)	1,474,575
15	860,022	216,214	67,028	(31,783)	7,557	23,499	62,289	34,263	3,481	1,242,570
16	1,748,527	332,386	149,759	(33,185)	17,045	51,244	121,879	54,642	(2,382)	2,439,915
17	959,469	286,368	91,070	(18,321)	16,475	26,566	67,792	29,732	(2,052)	1,457,099
18	885,212	236,942	66,162	(24,645)	13,410	22,978	62,343	29,230	(1,383)	1,290,249
19	575,571	158,699	38,850	(12,934)	11,358	17,961	41,941	21,722	(1,258)	851,910
20	871,766	231,393	91,698	11,335	26,320	21,946	60,195	39,089	(1,706)	1,352,036
21	854,866	288,315	188,127	162,012	62,831	32,120	60,662	43,123	(2,452)	1,689,604
22	1,050,766	336,359	184,100	100,685	42,931	53,164	72,875	49,162	(2,149)	1,887,893
23	997,382	310,752	95,126	(30,939)	25,540	28,035	75,344	42,174	616	1,544,030
VHA Total^a	\$20,088,768	\$5,851,747	\$2,543,145	\$0	\$442,000	\$642,719	\$1,431,621	\$800,000	\$0	\$31,800,000

Source: Department of Veterans Affairs, Veterans Health Administration, Office of Finance.

a. Totals may not add-up due to rounding

b. In January 2002, VISNs 13 and 14 were integrated as VISN 23.

As of FY2009, VHA operates 153 hospitals (medical centers), 135 nursing homes, 803 community-based outpatient clinics (CBOCs),¹⁴ 6 independent outpatient clinics, 271 Readjustment Counseling Centers (Vet Centers).¹⁵ VHA also operates 10 mobile outpatient clinics.

The VHA pays for care provided to veterans by private-sector providers on a fee basis under certain circumstances. Inpatient and outpatient care are also provided in the private sector to eligible dependents of veterans under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).¹⁶ The VHA also provides grants for construction of state-owned nursing homes and domiciliary facilities and collaborates with the Department of Defense (DOD) in sharing health care resources and services.

Apart from providing direct patient care to veterans,¹⁷ VHA's other statutory missions are to conduct medical research,¹⁸ to serve as a contingency back up to the Department of Defense (DOD) medical system during a national security emergency,¹⁹ to provide support to the National Disaster Medical System and the Department of Health and Human Services as necessary,²⁰ and to train health care professionals in order to provide an adequate supply of health personnel for VA and the Nation.²¹

Training of Health Care Professionals

VA's clinical training program is the largest provider of health care training in the United States.²² It is also the second largest federal payer (after Medicare) for health care training. In FY2008, a total of 109,882 health professionals had part or all of their clinical training at VA medical facilities (see **Figure 4**). This included 34,075 physician residents rotating through 9,545 funded graduate medical education (GME) slots (about 8.5% of total U.S. resident positions).²³ It should

¹⁴ Data on the number of CBOCs differ from source to source. Some sources count clinics located at VA hospitals while others count only free standing facilities. The number provided in this report excludes outpatient clinics located at VA hospitals.

¹⁵ In FY2009 VA plans to establish 39 new Vet Centers. The new Vet Centers are to be located in the following counties: Madison, AL; Maricopa, AZ; Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, and San Diego, CA; Fairfield, CT; Broward, Palm Beach, Pasco, Pinellas, Polk, and Volusia, FL; Cobb, GA; Cook, and DuPage, IL; Anne Arundel, Baltimore, and Prince George's, MD; Macomb and, Oakland, MI; Hennepin, MN; Greene, MO; Onslow, NC; Ocean, NJ; Clark, NV; Comanche, OK; Bucks, and Montgomery, PA; Bexar, Dallas, Harris, and Tarrant, TX; Virginia Beach, VA; King, WA; and Brown, WI. VA plans to have the 39 sites fully operational by the end of December 2009. In FY2010 VA plans to establish 28 new Vet Centers. These new Vet Centers would be located in: Mohave and Yuma Counties, AZ; San Luis Obispo, CA; Sussex County, DE; Bay, Collier, Lake, Marion, and Okaloosa Counties, FL; Muscogee and Richmond Counties, GA; Oahu (Western), HI; St. Joseph County, IN; Rapides County, LA; Grand Traverse County, MI; Boone County, MO; Cascade and Flathead Counties, MT; Stark County, OH; Deschutes County, OR; Lancaster County, PA; Horry County, SC; Jefferson and Taylor Counties TX; Washington County UT; Walla Walla County, WA; LaCrosse County, WI; and American Samoa.

¹⁶ For further information on CHAMPVA, see CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*, by Sidath Viranga Panangala.

¹⁷ 38 U.S.C. § 7301(b).

¹⁸ 38 U.S.C. § 7303.

¹⁹ 38 U.S.C. § 8111A.

²⁰ 38 U.S.C. § 8117(e).

²¹ 38 U.S.C. § 7302.

²² U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Healthcare Professionals—Recruitment and Retention*, 110th Cong., 1st sess., October 18, 2007 (Washington: GPO, 2008), p. 40.

²³ Department of Veterans Affairs, Veterans Health Administration, Office of Academic Affiliations, Briefing to the Congressional Research Service, April 15, 2009.

be noted here that about 3.5 individual physician residents rotate through each of the 9,545 funded positions.²⁴ Of the total U.S. physician residents about 31% (34,075) receive some or all of their training from the VA annually. Although a majority of VA's residency positions are in primary care, the Department also supports GME in recognized medical specialties and subspecialties.

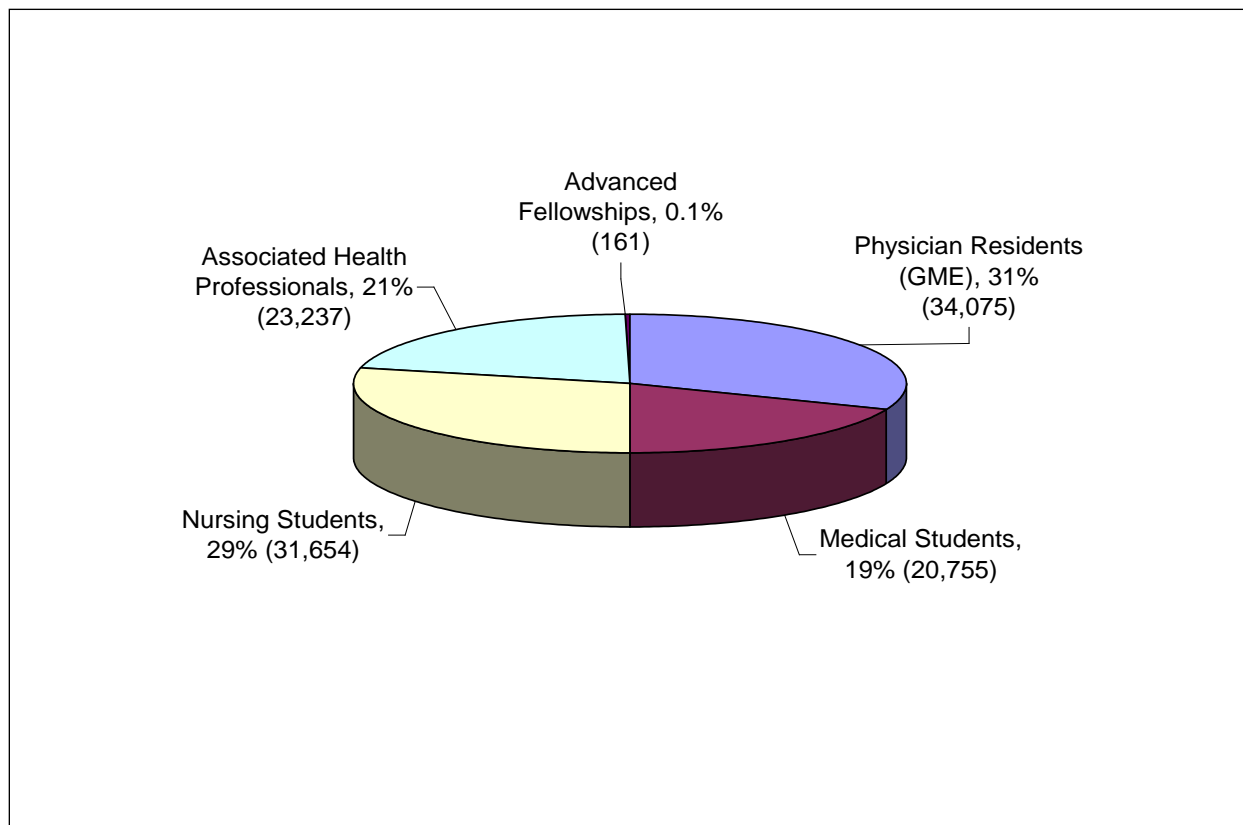
In late 2004, VA's Advisory Committee on GME initiated a review of VA's resident education program. The Advisory Committee was charged with examining the philosophy and deployment of VA's residency training positions (including the total number of positions, the specialty mix of resident physician training positions, and the geographic distribution of positions). The Advisory Committee undertook a broad assessment of graduate medical education in relationship to veterans' future health care needs. The Advisory Committee's recommendations called for increasing the number of residents in geographic areas and at sites of care where there are increased capacities to train; expanding training in areas of high relevance to VA; expanding training in areas of new and emerging specialties; and expanding affiliations with new VA sites of care.²⁵

As a result of this Advisory Committee's recommendation, in 2006 (academic year 2007-2008) VA began a GME enhancement program. The purpose of this multi-year program is to increase VA's share of U.S. resident positions from its low of 8.5% to the range of 10-11%. The five-year plan is designed to add approximately 2,000 positions to VA's pre-existing physician resident positions. In the first three years, the VA has added 967 residency positions to the base allocations of 72 VA facilities in 66 different specialty training programs.

²⁴ A single resident position may be filled by multiple residents. Allocations of fractions of slots are possible because residents may obtain only a part of their training at a VA medical center.

²⁵ The full report can be accessed at http://www.va.gov/oaa/archive/FACA_Report_2005.pdf, accessed on May 20, 2009.

Figure 4. VA Health Professionals Training Program: Percent Distribution of Program Participants, FY2008



Source: Chart prepared by Congressional Research Service, based on data provided by the Department of Veterans Affairs, Veterans Health Administration, Office of Academic Affiliations.

The Veteran Patient Population

During FY2009, the VHA had an estimated total enrolled veteran population of 8.3 million and provided medical care to about 5.4 million unique veteran patients (see **Table 3** and **Table 4**).²⁶ According to VHA estimates, the number of unique veteran patients is estimated to increase by approximately 116,000, from 5.42 million in FY2009 to 5.53 million in FY2010. As shown in **Table 4** there will be an estimated 2.1% increase in the total number of unique patients (both veterans and non-veterans), from 5.92 million in FY2009 to 6.05 million in FY2010. The number of patients includes veterans from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). In FY2010, VHA estimates that it will treat about 419,000 OIF and OEF veterans, an increase of about 56,000 patients, or 15.4%, over the FY2009 level. In FY2010, it is estimated that VA will be treating over 515,000 non-veterans, an increase of over 5,900 or 1.2%, over the FY2009 level.²⁷

²⁶ “Enrollees” are veterans who are currently enrolled in the VA health care system. “Unique patients” are those receiving medical care who are counted only once. In any given year, some enrollees do not seek any medical care, either because they do not become sick or because they rely on other health care resources, such as private health insurance, for care.

²⁷ Non-veterans include CHAMPVA patients, reimbursable patients with VA affiliated hospitals and clinics, care

The total number of outpatient visits, including visits to Vet Centers, reached 67.6 million during FY2008 and is projected to increase to approximately 70.9 million in FY2009 and 74.5 million in FY2010.²⁸ The VHA estimates that in FY2009 it will spend approximately 56.2% of its medical services obligations on outpatient care.²⁹

Table 3. Number of Veterans Enrolled in the VA Health Care System, FY2006-FY2010

Priority Groups ^a	FY2006 Actual	FY2007 Actual	FY2008 Actual	FY2009 Estimate	FY2010 Estimate
1	912,787	977,389	1,041,754	1,079,852	1,134,117
2	522,829	545,196	550,634	595,548	618,701
3	996,063	1,023,256	1,011,568	1,090,376	1,118,059
4	241,716	244,159	237,208	233,153	230,759
5	2,538,228	2,413,796	2,274,668	2,361,165	2,350,211
6	265,253	312,256	425,588	354,785	370,649
<i>Subtotal Priority Groups 1-6</i>	<i>5,476,876</i>	<i>5,516,052</i>	<i>5,541,420</i>	<i>5,714,879</i>	<i>5,822,496</i>
7	218,248	202,049	164,986	1,056,733	1,058,811
8	2,177,314	2,115,344	2,128,357	1,545,331	1,557,535
<i>Subtotal Priority Groups 7-8</i>	<i>2,395,562</i>	<i>2,317,393</i>	<i>2,293,343</i>	<i>2,602,064</i>	<i>2,616,346</i>
Total Enrollees	7,872,438	7,833,445	7,834,763	8,316,943	8,438,842

Source: Table prepared by Congressional Research Service based on data from Department of Veterans Affairs, *FY2010 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4, May 2009, pp. 1C-11.

a. For a description of the Priority Groups see **Appendix A**.

Table 4. Number of Patients Receiving Care from the VA, FY2006-FY2010

Priority Group ^a	FY2006 Actual	FY2007 Actual	FY2008 Actual	FY2009 Estimate	FY2010 Estimate
1	768,537	820,410	888,470	919,918	968,516
2	342,023	358,270	365,212	394,768	412,264
3	568,740	590,860	585,032	634,232	654,712
4	177,563	181,572	185,997	186,477	186,369

provided on a humanitarian basis, veterans of World War II allied nations, and employees receiving preventative occupational immunizations such as Hepatitis A&B and flu vaccinations.

²⁸ This number includes outpatient care provided on a contract basis and outpatient visits to readjustment counseling centers. Department of Veterans Affairs, *FY2010 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4, May 2009, pp. 1C-12.

²⁹ Ibid., p.1C-14.

Priority Group ^a	FY2006 Actual	FY2007 Actual	FY2008 Actual	FY2009 Estimate	FY2010 Estimate
5	1,645,781	1,544,328	1,484,467	1,580,609	1,590,953
6	134,425	155,939	199,882	174,184	181,944
<i>Subtotal Priority Groups 1-6</i>	<i>3,637,069</i>	<i>3,651,379</i>	<i>3,709,060</i>	<i>3,890,188</i>	<i>3,994,758</i>
7	197,901	173,149	147,785	619,888	622,101
8	1,195,612	1,191,161	1,221,424	909,816	918,896
<i>Subtotal Priority Groups 7-8</i>	<i>1,393,513</i>	<i>1,364,310</i>	<i>1,369,209</i>	<i>1,529,704</i>	<i>1,540,997</i>
Subtotal Unique Veteran Patients ^b	5,030,582	5,015,689	5,078,269	5,419,892	5,535,755
Non-veterans ^c	435,488	463,240	498,420	509,167	515,098
Total Unique Patients	5,466,070	5,478,929	5,576,689	5,929,059	6,050,853

Source: Table prepared by Congressional Research Service based on data from Department of Veterans Affairs, *FY2010 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4, May 2009, pp. IC-11.

- For a description of the Priority Groups see **Appendix A**.
- Unique veteran patients include Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans. These patients numbered: 155,272 in FY2006, 205,628 in FY2007, 261,019 in FY2008, and are estimated to be 363,275 in FY2009 and 419,256 in FY2010.
- Non-veterans include CHAMPVA patients, reimbursable patients with VA affiliated hospitals and clinics, care provided on a humanitarian basis, veterans of World War II allied nations, and employees receiving preventative occupational immunizations such as Hepatitis A&B and flu vaccinations.

Eligibility for Veterans Health Care

“The Promise of Free Health Care”

To understand some of the issues discussed in this report, it is important to understand eligibility for VA health care, the VA’s enrollment process, and its enrollment priority groups. VA health care is not an entitlement program. Contrary to numerous claims made concerning “promises” to military personnel and veterans with regard to “free health care for life,” not every veteran is automatically entitled to medical care from the VA.³⁰ Prior to eligibility reform in 1996, provisions of law governing eligibility for VA care were complex and not uniform across all levels of care. All veterans were technically “eligible” for hospital care and nursing home care, but eligibility did not by itself ensure access to care.

The Veterans’ Health Care Eligibility Reform Act of 1996, P.L. 104-262, established two eligibility categories and required the VHA to manage the provision of hospital care and medical services through an enrollment system based on a system of priorities.³¹ P.L. 104-262 authorized the VA to provide all needed hospital care and medical services to veterans with service-connected disabilities, former prisoners of war, veterans exposed to toxic substances and environmental hazards such as Agent Orange, veterans whose attributable income and net worth

³⁰ For a detailed discussion of “promised benefits,” see CRS Report 98-1006, *Military Health Care: The Issue of “Promised” Benefits*, by David F. Burrelli.

³¹ U.S. Congress, House Committee on Veterans Affairs, *Veterans’ Health Care Eligibility Reform Act of 1996*, report to accompany H.R. 3118, 104th Cong. 2nd sess., H.Rept. 104-690 p. 2.

are not greater than an established “means test,” and veterans of World War I. These veterans are generally known as “higher priority” or “core” veterans (see **Appendix A**, and discussed in more detail below).³² The other category of veterans are those with no service-connected disabilities and with attributable incomes above an established means test (see **Appendix C**).

P.L. 104-262 also authorized the VA to establish a patient enrollment system to manage access to VA health care. As stated in the report language accompanying P.L. 104-262, “the Act would direct the Secretary, in providing for the care of ‘core’ veterans, to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment system would operate.”³³

Furthermore, P.L. 104-262 was clear in its intent that the provision of health care to veterans was dependent upon the available resources. The committee report accompanying P.L. 104-262 states that the provision of hospital care and medical services would be provided to “the extent and in the amount provided in advance in appropriations acts for these purposes. Such language is intended to clarify that these services would continue to depend upon discretionary appropriations.”³⁴

VHA Health Care Enrollment

As stated previously, P.L. 104-262 required the establishment of a national enrollment system to manage the delivery of inpatient and outpatient medical care. The new eligibility standard was created by Congress to “ensure that medical judgment rather than legal criteria will determine when care will be provided and the level at which care will be furnished.”³⁵

For most veterans, entry into the veterans’ health care system begins by completing the application for enrollment. Some veterans are exempt from the enrollment requirement if they meet special eligibility requirements.³⁶ A veteran may apply for enrollment by completing the Application for Health Benefits (VA Form 10-10EZ) at any time during the year and submitting the form online or in person at any VA medical center or clinic, or mailing or faxing the completed form to the medical center or clinic of the veteran’s choosing.³⁷ Once a veteran is enrolled in the VA health care system, the veteran remains in the system and does not have to reapply for enrollment annually. However, those veterans who have been enrolled in Priority Group 5 (see **Appendix A**, discussed in more detail below) based on income must submit a new VA Form 10-10EZ annually with updated financial information demonstrating inability to defray the expenses of necessary care.³⁸

³² Ibid., p.5.

³³ Ibid., p.6.

³⁴ Ibid., p.5.

³⁵ Ibid., p.4.

³⁶ Veterans do not need to apply for enrollment in the VA’s health care system if they fall into one of the following categories: veterans with a service-connected disability rated 50% or more (percentages of disability are based upon the severity of the disability; and those with a rating of 50% or more are placed in Priority Group 1); veterans for whom less than one year has passed since the veteran was discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, but the VA has not yet rated; or the veteran is seeking care from the VA only for a service-connected disability (even if the rating is only 10%).

³⁷ VA Form 10-10EZ is available at <https://www.1010ez.med.va.gov/sec/vha/1010ez/>, accessed July 16, 2009.

³⁸ 38 C.F.R. §17.36 (d)(3)(iv) (2008).

Veteran's Status

Eligibility for VA health care is based primarily on “veteran’s status” resulting from military service. Veteran’s status is established by active-duty status in the military, naval, or air service and an honorable discharge or release from active military service. A veteran with an “other than honorable” discharge or “bad conduct” discharge may still retain eligibility for VA health care benefits for disabilities incurred or aggravated during service in the military.³⁹

Generally, persons enlisting in one of the armed forces after September 7, 1980, and officers commissioned after October 16, 1981, must have completed two years of active duty or the full period of their initial service obligation to be eligible for VA health care benefits. Servicemembers discharged at any time because of service-connected disabilities are not held to this requirement. Also, reservists that were called to active duty and who completed the term for which they were called, and who were granted an other than dishonorable discharge, are exempt from the 24 continuous months of active duty requirement. National Guard members who were called to active duty by federal executive order are also exempt from this two-year requirement if they (1) completed the term for which they were called and (2) were granted an other than dishonorable discharge.

When not activated to full-time federal service, members of the reserve components and National Guard have limited eligibility for VA health care services. Members of the reserve components may be granted service-connection for any injury they incurred or aggravated in the line of duty while attending inactive duty training assemblies, annual training, active duty for training, or while going directly to or returning directly from such duty. In addition, reserve component service members may be granted service-connection for a heart attack or stroke if such an event occurs during these same periods. The granting of service-connection makes them eligible to receive care from the VA for those conditions. National Guard members are not granted service-connection for any injury, heart attack, or stroke that occurs while performing duty ordered by a governor for state emergencies or activities.⁴⁰

After veterans’ status has been established, the VA next places applicants into one of two categories. The first group is composed of veterans with service-connected disabilities or with incomes below an established means test. These veterans are regarded by the VA as “high priority” veterans, and they are enrolled in Priority Groups 1-6 (see **Appendix A**). Veterans enrolled in Priority Groups 1-6 include

- veterans in need of care for a service-connected disability;
- veterans who have a compensable service-connected condition;
- veterans whose discharge or release from active military, naval, or air service was for a compensable disability that was incurred or aggravated in the line of duty;
- veterans who are former prisoners of war (POWs);
- veterans awarded the Purple Heart;
- veterans who have been determined by VA to be catastrophically disabled;
- veterans of World War I;
- veterans who were exposed to hazardous agents (such as Agent Orange in Vietnam) while on active duty; and

³⁹ For a detailed description of discharge criteria see CRS Report RL33113, *Veterans Affairs: Basic Eligibility for Disability Benefit Programs*, by Douglas Reid Weimer.

⁴⁰ 38.U.S.C. §101(24); 38 C.F.R. §3.6(c).

- veterans who have an annual income and net worth below a VA-established means test threshold.

The VA looks at applicants' income and net worth to determine their specific priority category and whether they have to pay copayments for nonservice-connected care. In addition, veterans are asked to provide the VA with information on any health insurance coverage they have, including coverage through employment or through a spouse. The VA may bill these payers for treatment of conditions that are not a result of injuries or illnesses incurred or aggravated during military service. **Appendix B** provides information on what categories of veterans pay for which services.

The second group of veterans is composed of those who do not fall into one of the first six priority groups—primarily veterans with nonservice-connected medical conditions and with incomes and net worth above the VA-established means test threshold. These veterans are enrolled in Priority Group 7 or 8.⁴¹ **Appendix C** provides information on income thresholds for VA health care benefits.

Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans

The National Defense Authorization Act (NDAA), FY2008 (P.L. 110-181) extended the period of enrollment for VA health care from two to five years for veterans who served in a theater of combat operations after November 11, 1998 (generally, OEF and OIF veterans who served in a combat theater).

According to the VA, currently enrolled combat veterans will have their enrollment eligibility period extended to five years from their most recent date of discharge. New servicemembers discharged from active duty on or after January 28, 2003, could enroll for a period of up to five years after their most recent discharge date from active duty. Veterans who served in a theater of combat, and who never enrolled, and were discharged from active duty between November 11, 1998 and January 27, 2003 may apply for this enhanced enrollment opportunity through January 27, 2011.

Generally, new OEF and OIF veterans are assigned to Priority Group 6, unless eligible for a higher Priority Group, and are not charged copays for medication and/or treatment of conditions that are potentially related to their combat service. Veterans who enroll in the VA health care system under this extended enrollment authority will continue to be enrolled even after the five-year eligibility period ends. At the end of the five-year period, veterans enrolled in Priority Group 6 may be re-enrolled in Priority Group 7 or 8, depending on their service-connected disability status and income level, and may be required to make copayments for nonservice-connected conditions. The above criteria apply to National Guard and Reserve personnel who were called to active duty by federal executive order and served in a theater of combat operations after November 11, 1998.

Medical Benefits Package

Once enrolled all veterans are offered a standard medical benefits package. This package includes a full range of inpatient, outpatient, and preventive medical services such as: medical, surgical,

⁴¹ The VA considers a veteran's previous year's total household income (both earned and unearned income, as well as his/her spouse's and dependent children's income). Earned income is usually wages received from working. Unearned income includes interest earned, dividends received, money from retirement funds, Social Security payments, annuities, and earnings from other assets. The number of persons in the veterans' family will be factored into the calculation to determine the applicable income threshold. 38 C.F.R. § 17.36(b)(7) (2008).

and mental health care, including care for substance abuse; prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system; durable medical equipment and prosthetic and orthotic devices, including eyeglasses and hearing aids; home health services, hospice care, palliative care, and institutional respite care; and noninstitutional adult day health care and noninstitutional respite care; and periodic medical exams, among other services.⁴²

Priority Groups and Scheduling Appointments

The VHA is mandated to provide priority care for non-emergency outpatient medical care for *any* condition of a service-connected veteran rated 50% or more, or for a veteran's service-connected condition.⁴³ According to VHA policies, patients with emergency or urgent medical needs must be provided care, or must be scheduled to receive care as soon as practicable, independent of service-connected status, and whether care is purchased or provided directly by the VA. Veterans whose conditions are 50% or more service-connected disabled must be scheduled to be seen within 30 days of the desired date for any condition.

Veterans who are rated less than 50% service-connected disabled, and who require care for a service-connected condition, must be scheduled to be seen within 30 days of the desired date. When VHA staff is in doubt as to whether the request for care is for a service-connected condition, they are required to assume, on behalf of the veteran, that the veteran is entitled to priority access and schedule within 30 days of the desired date.⁴⁴

Veterans who are rated less than 50% service-connected, and who require care for a nonservice-connected condition, are to be scheduled to be seen within 120 days of the desired date. According to VHA policies, all outpatient appointment requests must be acted on as soon as possible, but no later than seven calendar days from the date of the request. The VHA also requires that priority scheduling of any veteran must not affect the medical care of any other previously scheduled veteran. Furthermore, VHA guidelines state that veterans with service-connected conditions cannot be prioritized over other veterans with more acute health care needs.⁴⁵

Formulation of VHA's Budget

Historically, the major determinant of VHA's budget size and character was the number of operating beds—which was controlled by Congress.⁴⁶ The preliminary budget estimate, to a large extent, was based on the funding and activity of the previous year. VHA developed system-wide workload estimates, by type of care, by forecasts submitted by field stations. Unit costs were derived from the field stations' reports of the estimated distribution of expenses by type of care. Costs associated with new programs were estimated by VA central office and added to the budget estimate.⁴⁷ The costs associated with staffing improvements, pay increases and inflation were also

⁴² A detail listing of VHA's standardized medical benefits package is available at 38 C.F.R. § 17.38 (2008).

⁴³ VHA Directive 2006-055, October 11, 2006.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ U.S. Congress, House Committee on Veterans' Affairs, *Health Care for American Veterans*, prepared by the National Academy of Sciences, National Research Council, 95th Cong., 1st sess., June 7, 1977, House Committee Print No. 36 (Washington: GPO, 1977), p. 37.

⁴⁷ Ibid, p. 42.

added to this estimate. Therefore, it could be stated that the principal assumption at each phase of the budget formulation process was that the preceding year's budget was the starting point.⁴⁸

In 1996, Congress enacted the Departments of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act of 1997 (P.L. 104-204). This Act required VHA to develop a plan for the allocation of health care resources to ensure that veterans eligible for medical care who have similar economic status and eligibility priority have similar access to such care, regardless of where they reside.⁴⁹ The plan was to “account for forecasts in expected workload and to ensure fairness to facilities that provide cost-efficient health care.”⁵⁰

In response to the above-mentioned Congressional mandate, as well as the mandate in the Health Care Eligibility Reform Act of 1996 (P.L. 104-262) that required the VHA to establish a priority-based enrollment system, VHA established the Enrollee Health Care Projection Model in 1998. The VHA's the Enrollee Health Care Projection Model (EHCPM), which has evolved over time, develops estimates of future veteran enrollment, enrollees' expected utilization of health care services, and the costs associated with that utilization. These 20-year projections are by fiscal year, enrollment priority, age, Veterans Integrated Service Networks (VISN), market, and facility. The VHA budget is formulated using the model projections.⁵¹

VHA's budget request to Congress begins with the formulations of the budget based on the EHCPM to estimate the demand for medical services among veterans in future years. These estimates are then used to develop a budget request that is then included with the total VA budget request to Congress.

Funding for the VHA

The VHA is funded through multiple appropriations accounts that are supplemented by other sources of revenue. Although the appropriations account structure has been subject to change from year to year, the appropriation accounts used to support the VHA traditionally include medical care, medical and prosthetic research, and medical administration. In addition, Congress also appropriates funds for construction of medical facilities through a larger appropriations account for construction for all VA facilities. In FY2004, “to provide better oversight and [to] receive a more accurate accounting of funds,” Congress changed the VHA's appropriations structure.⁵² The Department of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act, 2004 (P.L. 108-199, H.Rept. 108-401), funded VHA through four accounts: (1) medical services, (2) medical administration (currently known as medical support and compliance), (3) medical facilities, and (4) medical and prosthetic research. Provided below are brief descriptions of these accounts.

⁴⁸ Ibid.

⁴⁹ Department of Veterans Affairs, Office of Inspector General, *Report of Audit Congressional Concerns Over Veterans Health Administration's Budget Execution*, Report No. 06-01414-160, Washington, DC, June 30, 2006, p. 2.

⁵⁰ Ibid.

⁵¹ For a discussion of the EHCPM see CRS Report R40489, *Advance Appropriations for Veterans' Health Care: Issues and Options for Congress*, by Sidath Viranga Panangala, and also see Katherine M. Harris, James P. Galasso, and Christine Eibner, *Review and Evaluation of the VA Enrollee Health Care Projection Model*, The RAND Corporation, Center for Military Health Policy Research, 2008.

⁵² U.S. Congress, Conference Committees, *Consolidated Appropriations Act, 2004*, conference report to accompany H.R. 2673, 108th Cong., 1st sess., H.Rept. 108-401, p. 1036.

Medical Services

The medical services account covers expenses for furnishing inpatient and outpatient care and treatment of veterans and certain dependents, including care and treatment in non-VA facilities; outpatient care on a fee basis; medical supplies and equipment; salaries and expenses of employees hired under Title 38, United States Code; and aid to state veterans homes. In its FY2008 budget request to Congress, the VA requested the transfer of food service operations costs from the medical facilities appropriations to the medical services appropriations. The House and Senate Appropriations Committees concurred with this request.⁵³

Medical Support and Compliance (Previously Medical Administration)

The medical support and compliance account provides funds for the expenses related to the administration of hospitals, nursing homes, and domiciliaries, billing and coding activities, public health and environmental hazard programs, quality and performance management, medical inspection, human research oversight, training programs and continuing education, security, volunteer operations, and human resources management.

Medical Facilities

The medical facilities account covers, among other things, expenses for the maintenance and operation of VHA facilities; administrative expenses related to planning, design, project management, real property acquisition and disposition, construction, and renovation of any VHA facility; leases of facilities; and laundry services.

Medical and Prosthetic Research

This account provides funding for VA researchers to investigate a broad array of veteran-centric health topics, such as treatment of mental health conditions; rehabilitation of veterans with limb loss, traumatic brain injury, and spinal cord injury; organ transplantation; and the organization of the health care delivery system. VA researchers receive funding not only through this account but also from the Department of Defense (DOD), the National Institutes of Health (NIH), and private sources.

Unlike other federal agencies such as NIH and DOD, VA does not have the statutory authority to make research grants to colleges and universities, cities and states, or any other non-VA entities. In general, VA's research program is intramural, that is, research is performed by VA investigators at VA facilities and approved off-site locations.

Medical Care Collections Fund (MCCF)

In addition to direct appropriations accounts mentioned above, the Committees on Appropriations include medical care cost recovery collections when considering the amount of resources needed to provide funding for the VHA. The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), enacted into law in 1986, gave the VHA the authority to bill some veterans and

⁵³ The cost of food service operations support hospital food service workers, provisions, and supplies related to the direct care of patients.

most health care insurers for nonservice-connected care provided to veterans enrolled in the VA health care system, to help defray the cost of delivering medical services to veterans.⁵⁴ This law also established means testing for veterans seeking care for nonservice-connected conditions. However, P.L. 99-272 did not provide the VA with specific authority to retain the third-party payments it collected and VA was required to deposit these third-party collections in the General Fund of the U.S. Treasury.

The Balanced Budget Act of 1997 (P.L. 105-33) gave the VHA the authority to retain these funds in the Medical Care Collections Fund (MCCF). Instead of returning the funds to the Treasury, the VA can use them for medical services for veterans without fiscal year limitations.⁵⁵ To increase the VA's third-party collections, P.L. 105-33 also gave the VA the authority to change its basis of billing insurers from "reasonable costs" to "reasonable charges."⁵⁶ This change in billing was intended to enhance VA collections to the extent that reasonable charges result in higher payments than reasonable costs.⁵⁷ In FY2004, the Administration's budget requested consolidating several existing medical collections accounts into one MCCF. The conferees of the Consolidated Appropriations Act of 2004 (H.Rept. 108-401) recommended that collections that would otherwise be deposited in the Health Services Improvement Fund (former name), Veterans Extended Care Revolving Fund (former name), Special Therapeutic and Rehabilitation Activities Fund (former name), Medical Facilities Revolving Fund (former name), and the Parking Revolving Fund (former name) should be deposited in MCCF.⁵⁸ The Consolidated Appropriations Act of 2005 (P.L. 108-447, H.Rept. 108-792) provided the VA with permanent authority to deposit funds from these five accounts into the MCCF. The funds deposited into the MCCF would be available for medical services for veterans. These collected funds do not have to be spent in any particular fiscal year and are available until expended.

Consolidated Patient Accounting Centers (CPACs)

In 2005, VA established a Mid-Atlantic CPAC in North Carolina to help maximize its collections by using a private-sector model tailored to VA's billing and collection needs.⁵⁹ The conferees of the FY2006 Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act (P.L. 109-114, H.Rept. 109-305) required the VA to establish a revenue improvement demonstration project. The purpose of this pilot project was to provide a "comprehensive restructuring of the complete revenue cycle including cash-flow management and accounts receivable."⁶⁰ The conferees included this provision because the Appropriations Committees were concerned that the VHA was collecting only 41% percent of the billed amounts from third-party insurance companies. Due to their similar missions, VA established the Revenue Improvement

⁵⁴ Veterans' Health-Care and Compensation Rate Amendments of 1985; 100 Stat. 372, 373, 383.

⁵⁵ For a detailed history of funding for VHA from FY1995 to FY2004, see CRS Report RL32732, *Veterans' Medical Care Funding: FY1995-FY2004*, by Sidath Viranga Panangala.

⁵⁶ Under "reasonable costs," the VA billed insurers based on its average cost to provide a particular episode of care. Under "reasonable charges," the VA bills insurers based on market pricing for health care services.

⁵⁷ U.S. Government Accountability Office (GAO), *VA Health Care: Third-Party Charges Based on Sound Methodology; Implementation Challenges Remain*, GAO/HEHS-99-124, June 1999.

⁵⁸ For a detailed description of these former accounts, see CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala.

⁵⁹ U.S. Congress, House Committee on Veterans' Affairs, *Veterans' Health Care Policy Enhancement Act of 2008*, report to accompany H.R. 6445, 110th Cong., 2nd sess., July 29, 2008, H.Rept. 110-789, p. 7.

⁶⁰ U.S. Congress, Conference Committees, *Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act, 2006*, conference report to accompany H.R. 2528, 109th Congress, 1st session, H.Rept. 109-305, p. 43.

Demonstration Project at the Mid-Atlantic CPAC.⁶¹ There are eight VA medical centers under the CPAC demonstration project. In a report issued in June 2008, the Government Accountability Office (GAO) stated that VA had ineffective controls over medical center billings.⁶² The GAO estimated that \$1.2 to \$1.4 billion dollars are going uncollected by VA. Furthermore, in the same 2008 report, GAO noted that the Mid-Atlantic CPAC achieved better billing performance and has been able to reduce billing times.⁶³ The Veterans Mental Health and Other Improvements Act of 2008 (P.L. 110-387) required the VA to establish, within five years, no more than seven CPACs modeled after the existing CPAC and Revenue Improvement Demonstration Project in Asheville, North Carolina.

As shown in **Table 5** MCCF collections increased from \$1.5 billion in FY2003 to \$2.4 billion in FY2008. During this same period, first-party collections increased by 35%, from \$685 million to \$922 million. In FY2008, first-party collections represented approximately 37.2% of total MCCF collections.

Table 5. Medical Care Collections, FY2003-FY2008

(\$ in thousands)

	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual	FY2008 Actual
First-party pharmacy copayments ^a	\$576,554	\$623,215	\$648,204	\$723,027	\$760,616	\$749,685
First-party copayments for inpatient and outpatient care	104,994	113,878	118,626	135,575	150,964	168,274
First-party long-term care copayments ^b	3,461	5,077	5,411	4,347	3,699	3,751
Third-party insurance collections	804,141	960,176	1,055,597	1,095,810	1,261,346	1,497,449
Enhanced use leasing revenue ^c	234	459	26,861	3,379	1,692	1,422
Compensated work therapy collections ^d	38,834	40,488	36,516	40,081	43,296	52,372
Parking fees ^e	3,296	3,349	3,443	3,083	3,136	3,355
Compensation and pension living expenses ^f	376	634	2,431	2,075	1,904	1,572
MCCF Total	1,531,890	1,747,276	1,897,089	2,007,377	2,226,653	2,477,880

Sources: Table prepared by Congressional Research Service, based on data provided by the VA, and Department of Veterans Affairs, *FY2010 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 2 of 4, May 2009, pp. 1C-8.

⁶¹ U.S. Congress, House Committee on Veterans' Affairs, *Veterans' Health Care Policy Enhancement Act of 2008*, report to accompany H.R. 6445, 110th Cong., 2nd sess., July 29, 2008, H.Rept. 110-789, p. 7.

⁶² For details on whether medical centers under the CPAC initiative had more effective controls over third-party billings and collections, see U.S. Government Accountability Office, *VA Health Care: Ineffective Controls over Medical Center Billings and Collections Limit Revenue from Third- Party Insurance Companies*, GAO-08-675, June 2008.

⁶³ Ibid.

Notes: The following accounts were not consolidated into the MCCF until FY2004: enhanced use leasing revenue, compensated work therapy collections, parking fees, and compensation and pension living expenses. Collection figures for these accounts for FY2003 are provided for comparison purposes.

- a. In FY2002, Congress created the Health Services Improvement Fund (HSIF) to collect increases in pharmacy copayments (from \$2 to \$7 for a 30-day supply of outpatient medication) that went into effect on February 4, 2002. The Consolidated Appropriations Resolution, 2003 (P.L. 108-7) granted the VA the authority to consolidate the HSIF with the MCCF and granted permanent authority to recover copayments for outpatient medications.
- b. Authority to collect long-term care copayments was established by the Millennium Health Care and Benefits Act (P.L. 106-117). Certain veteran patients receiving extended care services from VA providers or outside contractors are charged copayments.
- c. Under the enhanced-use lease authority, the VA may lease land or buildings to the private sector for up to 75 years. In return the VA receives fair consideration in cash and/or in-kind. Funds received as monetary considerations may be used to provide care for veterans.
- d. The compensated work therapy program is a comprehensive rehabilitation program that prepares veterans for competitive employment and independent living. As part of their work therapy, veterans produce items for sale or undertake subcontracts to provide certain products and/or services, such as providing temporary staffing to a private firm. Funds collected from the sale of these products and/or services are deposited into the MCCF.
- e. The Parking program provides funds for construction and acquisition of parking garages at VA medical facilities. The VA collects fees for use of these parking facilities.
- f. Under the compensation and pension living expenses program, veterans who do not have either a spouse or child would have their monthly pension reduced to \$90 after the third month a veteran is admitted for nursing home care. The difference between the veteran's pension and the \$90 is used for the operation of the VA medical facility.

FY2009 Budget Summary⁶⁴

On February 4, 2008, President George W. Bush submitted his FY2009 budget proposal to Congress. The Administration requested a total of \$39.2 billion (excluding collections) for VHA. This was a 5.3%, or \$2 billion increase compared to the FY2008 enacted level. Including total available resources (including medical collections) the Administration's budget would have provided \$41.1 billion for VHA. The President's budget proposal also requested \$4.7 billion for the medical facilities account, an increase of \$561 million over the FY2008 enacted level. The Administration's budget proposal for FY2009 requested \$442 million for the medical and prosthetic research account, a 7.9% decrease (\$38 million) below the FY2008 enacted level. As in previous budget requests (FY2003 through FY2008), the Administration's FY2009 budget request included several cost-sharing proposals.

House Action

On August 1, 2008, the House passed the Military Construction and Veterans Affairs Appropriations bill (H.R. 6599; H.Rept. 110-775), for FY2009 (MILCON-VA Appropriations bill). The House-passed bill provided \$40.8 billion for VHA, a \$1.6 billion increase over the Administration's FY2009 request, and \$3.6 billion over the FY2008 enacted amount. This amount included \$31 billion for the medical services account, \$4.4 billion for the medical support and compliance account, \$5 billion for the medical facilities account, and \$500 million for the medical and prosthetic research account.

⁶⁴ For a detailed description of appropriations for the Veterans Health Administration for FY2009, see CRS Report RL34598, *Veterans Medical Care: FY2009 Appropriations*, by Sidath Viranga Panangala.

Senate Committee Action

On July 17, 2008, the Senate Appropriations Committee marked up its version of the FY2009 Military Construction and Veterans Affairs and Related Agencies Appropriations bill (S. 3301, S.Rept. 110-428). The Senate Appropriations Committee recommended \$41.1 billion (excluding collections) for VHA for FY2009. This was a 4.8% increase over the FY2009 request, and \$294 million above the House Appropriations Committee-recommended amount. S. 3301, as marked up by the Committee, also provided \$5.0 billion for medical facilities, and \$527 million for the medical and prosthetic research account. The full Senate did not consider S. 3301.

Final MILCON-VA Appropriations Act of 2009

Prior to the start of FY2009, a compromise version of H.R. 6599 and S. 3301 was included as Division E in the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (H.R. 2638). The bill was signed into law on September 30, 2008, as P.L. 110-329. The MILCON-VA Appropriations Act of 2009 provided a total of \$40.9 billion (excluding collections) for VHA.

American Recovery and Reinvestment Act (P.L. 111-5) Funds

VHA received \$1.0 billion for the medical facilities account under the American Recovery and Reinvestment Act of 2009, for non-recurring maintenance projects and renewable energy and energy efficiency projects across VHA facilities. Non-recurring maintenance projects include patient privacy corrections, life safety corrections (such as installation of fire walls and fire barrier walls and automatic sprinkler systems), utility system upgrades, and mental health improvements.

FY2010 VHA Budget

President's Request

On February 26, 2009, President Barack Obama released an initial budget outline for FY2010.⁶⁵ The initial budget outline did not provide details on funding levels for VHA. On May 7, the Administration released the full VHA budget proposal for FY2010. The President requested a total of \$45.1 billion for VHA (excluding collections). This is a 7.4 % increase over the FY2009 enacted amount of approximately \$42 billion (see **Table 7**). This amount includes \$34.7 billion in appropriated budget authority for the medical services account. According to the Administration's budget proposal this level of funding would allow for the gradual expansion of enrollment of Priority Group 8 veterans. VHA plans to enroll nearly 550,000 eligible Priority Group 8 veterans into the VA health care system between 2010 and 2013 (see discussion of Priority Group 8 veterans later in this report).

For FY2010, the Administration requested \$5.1 billion for the medical support and compliance account. This is a 14.6% over the FY2009 enacted amount. The President's request also includes \$4.7 billion for the medical facilities account, a decrease of 22.2% compared to the enacted amount. The reason for this decrease in funding is because the Administration is planning to use about \$490 million of the \$1.0 billion appropriated in the American Recovery and Reinvestment

⁶⁵ Office of Management and Budget, *A New Era of Responsibility: Renewing America's Promise*, February 26, 2009.

Act of 2009 (P.L. 111-5) for non-recurring maintenance and energy projects during FY2009 and the remaining \$510 million in FY2010 for these same type of projects.⁶⁶ Furthermore, the President's request included \$580 million for the medical and prosthetic research account.

The Administration's budget proposal did not include specific amounts for advance appropriations for veterans medical care in FY2011. However, in its budget submissions to Congress it indicated that it would work with Congress to provide advance appropriations for the VA medical care program.⁶⁷

FY2010 Congress Congressional Budget Resolution⁶⁸

On March 25, 2009, the House Budget Committee marked up and voted to report the House version of the FY2010 budget resolution (H.Con.Res. 85, H.Rept. 111-60). The House agreed to H.Con.Res. 85 on April 2. H.Con.Res. 85 as agreed to by the House provided \$53.3 billion in discretionary budget authority, and \$53.1 billion in mandatory budget authority for VA programs. A majority of this discretionary funding is for VA medical care. The House agreed upon version of the budget resolution affirmed that "VA should not be authorized to bill private insurance companies for treatment of health conditions that are related to veterans' military service."⁶⁹ H.Con.Res. 85 did not contain any language exempting certain VHA accounts against a point of order if funded under an advance appropriation for FY2011.

On March 26, the Senate Budget Committee voted to report the Senate version of the FY2010 budget resolution (S.Con.Res. 13). The Senate agreed to S.Con.Res. 13 on April 2. S.Con.Res. 13 as agreed to by the Senate provides \$53.2 in discretionary budget authority and \$53.1 billion in mandatory budget authority for VA programs.

During the Senate debate of S.Con.Res. 13, Senator James Inhofe offered an amendment (S.Amdt. 742) that was adopted by the Senate. This amendment allowed for an advance appropriation for the medical services, medical administration, medical facilities, and medical and prosthetic research accounts of VHA and did not subject those accounts to a point of order under section 302 of S.Con.Res. 13

After negotiations between the two chambers, the House and Senate agreed to the conference report to accompany the FY2010 budget resolution (S.Con.Res. 13, H.Rept. 111-89) on April 29. The conference agreement provides \$53.4 billion in discretionary budget authority and \$53.1 billion in mandatory budget authority for VA programs. Sections 402 and 424 of the conference agreement included language exempting the following VA accounts from a point of order against advance appropriations: medical services, medical support and compliance, and medical facilities.

House Action

The House Subcommittee on Military Construction and Veterans Affairs and Related Agencies marked-up a draft version of the Military Construction and Veterans Affairs Appropriations Act, 2010 (MILCON-VA Appropriations Act of 2010) on June 16, 2009. On June 24, the House Committee on Appropriations marked-up a draft version of the MILCON-VA Appropriations Act

⁶⁶ Office of Management and Budget, *Budget of the United States Government: Fiscal Year 2010*, Appendix, May 2009, p. 1027.

⁶⁷ Ibid. p. 1335.

⁶⁸ For a detailed analysis of the FY2010 budget resolution, see CRS Report R40559, *S.Con.Res. 13: The Budget Resolution for FY2010*, by Megan Suzanne Lynch and Mindy R. Levit.

⁶⁹ U.S. Congress, House Committee on the Budget, *Concurrent Resolution on the Budget-FY2010*, report to accompany H.Con.Res. 85, 111th Cong., 1st sess., March 27, 2009, H.Rept. 111-60 (Washington: GPO, 2009), p. 38.

of 2010, and the bill was reported on June 26 (H.R. 3082, H.Rept. 111-188). H.R. 3082 as passed by the committee provided a total of approximately \$45.1 billion for the Veterans Health Administration (VHA) for FY2010. The House Appropriations Committee provided \$34.7 billion for medical services, \$4.9 billion for medical support and compliance, \$4.8 billion for the medical facilities, and \$580 million for the medical and prosthetic research accounts. Apart from minor adjustments to the funding levels for each of the above accounts, the House Committee approved measure provided about the same funding levels as the President's request. The House Appropriations Committee also provided advance appropriations totaling \$48.2 billion for the medical services, medical support and compliance, and medical facilities accounts, an 8.3 % increase over the FY2010 House-passed funding level.

On July 10, the House passed H.R. 3082. During floor consideration of H.R. 3082 several amendments were offered. The following amendments changed the level of funding for some VHA accounts. H.Amdt. 313 offered by Representative Edwards on behalf of Representative Cohen transferred \$1 million from the general operating expenses account to the medical services account. This additional amount of funding would be used towards increasing the level of funding for VHA's Education Debt Reduction Program (EDRP).⁷⁰ Moreover, Representative Filner and Representative Langevin offered H.Amdt. 314. This amendment increased the level of funding for the Department of Veterans Affairs, Office of National Veterans' Sports Programs and Special Events by \$3.5 million and decreased funding for the VA's medical support and compliance account by \$3.5 million.⁷¹ The final House-passed amounts for VHA's accounts are provided in **Table 7**.

Senate Action

On July 6 2009, the Senate Subcommittee on Military Construction, Veterans Affairs, and Related Agencies approved a draft version of its MILCON-VA Appropriations Act of FY2010. On July 7, the full Senate Appropriations Committee reported S. 1407 (S.Rept. 111-40). The committee approved measure provides a total of \$45.2 billion for VHA, a \$159.3 million increase over the House-passed amount. S. 1407 as reported by the committee provides \$5.1 billion for the medical support and compliance account, \$203.5 million increase over the House-passed amount and same as the President's request (see **Table 7**). Similar to H.R. 3082, S. 1407 provided advance appropriations totaling \$48.2 billion for medical services, medical support and compliance, and medical facilities accounts (see **Table 7**).

On November 17, the Senate passed H.R. 3082 as amended. H.R. 3082 as amended by the Senate provided a total of \$45.2 billion for VHA, a \$160.0 million increase over the House-passed amount, and \$157.6 million over the President's request. This amount included \$34.7 billion for the medical services account, \$5.1 billion for medical support and compliance account, \$4.8 billion for medical facilities, and \$580.0 million for the medical and prosthetic research account (see **Table 7**). The Senate-passed version of H.R. 3082 provided advance appropriations totaling \$48.2 billion for medical services, medical support and compliance, and medical facilities accounts.

⁷⁰ "Military Construction and Veterans Affairs Appropriations Act, 2010," House, *Congressional Record*, vol. 155 (July 10, 2009), p. H7983.

⁷¹ Ibid. p. H7984.

Final MILCON-VA Appropriations Act, 2010

On December 10, 2009, the House adopted the conference report (H.Rept. 111-366) to accompany the Department of Transportation, Housing and Urban Development appropriations bill and retitled as the Consolidated Appropriations Act 2010 (H.R. 3288). The Senate adopted the conference report on December 13. Division E of the Consolidated Appropriations Act 2010 included a compromised version of the House and Senate passed versions of the MILCON-VA Appropriations Act of 2010. The Consolidated Appropriations Act, 2010, was signed into law on December 16, 2009 (P.L. 111-117). The Consolidated Appropriations Act, 2010 provides a total of \$45.1 billion for VHA without medical care collections, same as the Administration's request for FY2010. Among other things, P.L. 111-117 (H.Rept. 111-366) provides an additional \$1.0 million to the medical services account to fund the Education Debt Reduction Program to be used as an incentive when hiring mental health professionals,⁷² as well as an additional \$2.0 million for the Guide and Service Dog Program.⁷³ The conference agreement includes an advance appropriation for the medical services, medical support and compliance, and medical facilities accounts. According to the conference report "the goal of this advance appropriation is to provide the Veterans Health Administration with reliable and timely funding for their current services so the delivery of medical care is not disrupted."⁷⁴ See **Table 7** for detailed account level funding for VHA for FY2010.

Major Issues

Advance Appropriations⁷⁵

A coalition of veterans' service organizations (VSOs) has been calling on Congress to provide VHA with a budget which is "sufficient, timely, and predictable." These organizations have asserted that VHA has underestimated its budget in the past. Moreover, VSOs contend that Congress has not enacted the VA budget by the beginning of the fiscal year. According to these organizations the delays in the enactment of the budget have exacerbated operational challenges—such as, differing capital expenditures, delaying recruitment, restricting acquisitions, limiting maintenance—faced by VHA network directors. To mitigate these issues VSO's have proposed that Congress change the funding process for VHA to an advance appropriation.

⁷² The Education Debt Reduction Program (EDRP) was authorized with the enactment of the Veterans Programs Enhancement Act of 1998 (P.L. 105-368). It was amended by the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135). The EDRP was implemented in May 2002. The program serves as both a recruitment and a retention tool. EDRP authorizes VA to provide education debt reduction payments to employees with qualifying loans who are recently appointed to Title 38 U.S.C. positions providing direct-patient care services or services incident to direct-patient care for which recruitment and retention of qualified personnel is difficult. An employee is considered to be recently appointed to a position if the individual has held that position for less than 6 months.

⁷³ Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135) authorized the VA—at the discretion of the VA Secretary—to provide service dogs to veterans that are hearing or mobility impaired. Conference report language (H.Rept. 111-366) accompanying the Consolidated Appropriations Act, 2010 (P.L. 111-117) indicated the lack of progress the VA has made to fully implement P.L. 107-135 regarding the provision of guide dogs and service dogs to qualified veterans seeking such services.

⁷⁴ U.S. Congress, House Committee on Appropriations, *Departments of Transportation and Housing and Urban Development, and Related Agencies Appropriations Act, 2010*, conference report to accompany H.R. 3288, 111th Cong., December 8, 2009, H.Rept. 111-366 (Washington: GPO, 2009), p. 1349.

⁷⁵ For a detailed discussion of advance appropriations for VA health care accounts see CRS Report R40489, *Advance Appropriations for Veterans' Health Care: Issues and Options for Congress*, by Sidath Viranga Panangala.

In the 111th Congress H.R. 1016 and S. 423 were introduced, and these measures would authorize advance appropriations for certain medical care accounts of the Department of Veterans Affairs by providing two-fiscal year budget authority. The House passed H.R. 1016 (H.Rept. 111-171) as amended on June 23, and the Senate Veterans Affairs Committee reported S. 423 on July 8 (S.Rept. 111-41). S. 423 passed the Senate on August 6, 2009, as a substitute amendment to H.R. 1016. On October 8, the House agreed to the Senate amendment pursuant to H.Res. 804, and the Senate agreed to the House amendment to the Senate amendment on October 13. The Veterans Health Care Budget Reform and Transparency Act of 2009 (H.R. 1016) was signed into law (P.L. 111-81) on October 22. Under P.L. 111-81 beginning with FY2011, advance appropriations is authorized for the medical services, medical support and compliance, and medical facilities, accounts of the VHA. It also requires the VA to provide additional detailed budget estimates in support of advance appropriations for these accounts in the President's annual budget request to Congress. It also requires the VA to submit a report to Congress, no later than July 31 of each year, on the sufficiency of the Department's resources for the provision of medical care for the upcoming fiscal year. Furthermore, the Act would require the Comptroller General (U.S. Government Accountability Office) to conduct a study of the adequacy and accuracy of projections for health care expenditures and submit reports to the appropriate committees of Congress and to the Secretary of Veterans Affairs, in 2011, 2012, and 2013. These reports must state whether the amounts requested in the President's budget are consistent with anticipated expenditures for health care in such fiscal year as determined utilizing the Enrollee Health Care Projection Model.⁷⁶ The Comptroller General is required to submit these reports not later than 120 days after the President has submitted his annual budget request to Congress.

Priority Group 8 Veterans

Since January 17, 2003, the VA has not enrolled veterans in Priority Group 8 unless they had been previously enrolled in another priority group and no longer qualified for enrollment in that previous priority group (see **Appendix A**). Since the suspension was promulgated, veterans advocates have urged Congress to lift the suspension on Priority Group 8 veterans since they believe that all veterans must be able to receive care from the VA because they have served their country.⁷⁷

The Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104-262) included language that stipulated that medical care to veterans will be furnished to the extent appropriations were made available by Congress on an annual basis. Based on this statutory authority, the Secretary of Veterans Affairs announced on January 17, 2003 that VA would temporarily suspend enrolling Priority Group 8 veterans.⁷⁸ Those who enrolled prior to January 17, 2003 in VA's health care system were not to be affected by this suspension. VA claimed that, despite its funding increases, it could not provide all enrolled veterans with timely access to medical services because of the increase in the number of veterans seeking care from VA.⁷⁹

⁷⁶ For a discussion of the Enrollee Health Care Projection Model see CRS Report R40489, *Advance Appropriations for Veterans' Health Care: Issues and Options for Congress*, by Sidath Viranga Panangala.

⁷⁷ U.S. Congress, House Committee on Veterans' Affairs, *Priority Group 8 Veterans*, 110th Cong., 1st sess., June 20, 2007 (Washington: GPO, 2008), pp. 61-63.

⁷⁸ Department of Veterans Affairs, "Enrollment-Provision of Hospital and Outpatient Care to Veterans in Subpriorities of Priority Categories 7 and 8 and Annual Enrollment Level Decision," 68 *Federal Register* 2669-2673, January 17, 2003.

⁷⁹ *Ibid.*

The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (P.L. 110-329) was enacted on September 30, 2008. The accompanying report language stated that funding “has been provided within the Medical Services; Medical Support and Compliance; Medical Facilities; Construction, Minor Projects; and Information Technology Systems accounts to support increased enrollment for Priority 8 veterans whose income exceeds the current veterans means test and geographic means test income thresholds by 10 % or less.”⁸⁰ P.L. 110-329 provided \$375 million for FY2009 to fund this increased enrollment. On January 21, 2009, VA issued regulations indicating that it plans to enroll an estimated 258,705 new Priority Group 8 veterans.⁸¹ VA began enrolling new veterans starting June 15, 2009. **Table 6** provides details of the projected enrollment and expenditures under the current suspension scenario for FY2009, and estimated enrollment and expenditure figures under the proposed expanded enrollment scenario—reopening enrollment for Priority Group 8 veterans whose incomes exceed the current VA means test and geographic means test income thresholds by 10% or less—for FY2009. Furthermore, as stated before, the President’s FY2010 Budget Request to Congress also states that by 2013 VA plans to enroll about 550,000 new nonservice-connected veterans.⁸²

Table 6. Enrollment and Expenditures for FY2009- Under Current Policy and Under Expanded Enrollment Policy

\$ in Thousands

Priority Group	Estimated Enrollment	Estimated Expenditures
1	1,079,852	\$10,552,246
2	595,548	2,352,417
3	1,090,376	3,517,387
4	233,153	3,461,043
5	2,361,166	11,513,021
6	354,785	606,349
7	1,056,733	2,041,244
8	1,286,626	2,692,952
Total without Expansion	8,058,238	36,706,661
8(Expanded Enrollment) ^a	258,705	485,247
Total with Expansion	8,316,943	\$37,191,908

Source: Department of Veterans Affairs, “Expansion of Enrollment in the VA Health Care System,” 74 *Federal Register* 3535-3540, January 21, 2009.

Notes: Numbers may not add-up due to rounding.

- a. The total number of Priority Group 8 veterans after enrollment would be 1,545,331 and the estimated expenditures for this category of veterans would be \$3.2 billion.

A veteran applying for enrollment on or after June 15, 2009, who does not qualify for a higher priority group and whose income exceeds VA’s national and geographically-adjusted means test

⁸⁰ P.L. 110-329, U.S. Congress, House Committee on Appropriations, *Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009*, committee print, 110th Cong., 2nd sess., (Washington: GPO, 2008), p. 750.

⁸¹ Department of Veterans Affairs, “Expansion of Enrollment in the VA Health Care System,” 74 *Federal Register* 3535-3540, January 21, 2009.

⁸² Office of Management and Budget, *Budget of the U.S. Government: Fiscal Year 2010, Appendix*, Washington, DC, May 2009, p. 1024.

threshold by 10% or less will be placed in Priority Group 8b (if the Veteran has a noncompensable 0% service-connected condition) or 8d (if the Veteran has no service-connected condition) and enrolled in the VA health care system. This new financial threshold is referred to as the enrollment threshold (see **Appendix D**). Veterans who applied on or after January 1, 2009 and were denied enrollment have been notified that VA will re-determine their enrollment after June 15, 2009.

Because VA uses previous year's income in its enrollment determination, veterans who applied but were rejected for enrollment prior to January 1, 2009 may complete a VA Form 10-10EZR, Health Benefits Renewal form to have their eligibility for enrollment reassessed against the new enrollment threshold. Veterans may also self-determine their eligibility for enrollment under this new provision by entering their information into VA's on-line calculator⁸³

In general, veterans who are unable to defray the expenses of necessary care are eligible to receive care from the VA free of charge.⁸⁴ To determine if the veteran is eligible for free health care, the VA conducts a financial assessment. Under current law and regulations VA uses the veteran's previous year's (that is, the calendar year preceding the year in which the veteran applies for care or services) total household income (including income of the veteran, spouse, and dependent children) to make this determination.⁸⁵ However, in accordance with current VA regulations, if a veteran's current year income is projected to be less than his/her prior year's income, the veteran can submit a request for a hardship determination.⁸⁶ Thus, a veteran meeting this eligibility criterion may be placed in Priority Group 5 even though the veteran's prior year total gross household income is above the applicable national VA means test threshold.

Furthermore, under certain financial hardship circumstances, VA may use the projected income for the current year of the veteran, spouse, and dependent children if the projected income is below the VA's means test threshold and above a geographic means test threshold.⁸⁷ Therefore, a veteran meeting this eligibility criterion may be placed in Priority Group 7 even though the veteran's prior year total gross household income is above the applicable geographic means test for the area in which the veteran resides. Circumstances that would warrant financial hardship consideration would be loss of employment, business bankruptcy, or unreimbursed medical expenses paid by the veteran or spouse for a family member or others for whom the veteran has a "moral responsibility to assist." The hardship determination will be valid through the end of the calendar year in which it was approved. Veterans must contact their nearest VA medical facility to determine if they would be eligible to enroll in VA health care under the financial hardship criteria.

Beneficiary Travel Mileage Reimbursement

In general, the beneficiary travel program reimburses certain veterans for the cost of travel to VA medical facilities when seeking health care. P.L. 76-432, passed by Congress on March 14, 1940, mandated VA to pay either the actual travel expenses, or an allowance based upon the mileage traveled by any veteran traveling to and from a VA facility or other place for the purpose of examination, treatment, or care. P.L. 85-857, signed into law on September 2, 1958, authorized

⁸³ <http://www.va.gov/healtheligibility/apps/enrollmentcalculator/>.

⁸⁴ 38 U.S.C. § 1710(a)(2)(G).

⁸⁵ 38 U.S.C. § 1722; 38 C.F.R. § 17.36 (b)(7).

⁸⁶ 38 U.S.C. § 1722(e); 38 C.F.R. § 1747(d)(6).

⁸⁷ 38 C.F.R. § 1736(b)(7).

VA to pay necessary travel expenses to any veteran traveling to or from a VA facility or other place in connection with vocational rehabilitation counseling or for the purpose of examination, treatment, or care. However, this law changed VA's travel reimbursement into a discretionary authority by stating that VA "may pay" expenses of travel.

Due to rapidly increasing costs of the beneficiary travel program, on March 12, 1987, VA published final regulations that sharply curtailed eligibility for the beneficiary travel program.⁸⁸ Under these regulations beneficiary travel payments to eligible veterans were paid when specialized modes of transportation, such as ambulance or wheelchair van, were medically required. In addition, payment was authorized for travel in conjunction with compensation and pension examinations, as well as travel beyond a 100-mile radius from the nearest VA medical care facility. It also authorized the VA to provide transportation costs, when necessary, to transfer any veteran from one health care facility (either a VA or contract care facility) to another in order to continue care paid for by the VA. The following transportation costs were not authorized under these regulations:

- Cost of travel by privately owned vehicle in any amount in excess of the cost of such travel by public transportation unless public transportation was not reasonably accessible or was medically inadvisable.
- Cost of travel in excess of the actual expense incurred by any person as certified by that person in writing.
- Cost of routine travel in conjunction with admission for domiciliary care, or travel for family members of veterans receiving mental health services from the VA except for such travel performed beyond a 100-mile radius from the nearest VA medical care facility.

Travel expenses of all other veterans were not authorized unless the veterans were able to present clear and convincing evidence to show the inability to pay the cost of transportation, or except when medically-indicated ambulance transportation was claimed and an administrative determination was made regarding the veteran's ability to bear the cost of such transportation.⁸⁹

The Veterans' Benefits and Services Act of 1988 (P.L. 100-322, section 108) restored in large part, the travel reimbursement benefits. It required that if VA provides any beneficiary travel reimbursement under Section 111 of Title 38 U.S.C. in any given fiscal year, then payments must be provided in that year in the case of travel for health care services for all the categories of beneficiaries specified in the statute. In order to limit the overall cost of this program, the law imposed a \$3 one-way deductible applicable to all travel, except for veterans otherwise eligible for beneficiary travel reimbursement who are traveling by special modes of transportation such as ambulance, air ambulance, wheelchair van, or to receive a compensation and pension examination. In order to limit the overall impact on veterans whose clinical needs dictate frequent travel for VA medical care, an \$18-per-calendar-month cap on the deductible was imposed for those veterans who are pre-approved as needing to travel on a frequent basis.

Veterans may qualify for travel reimbursement if (1) they have a service-connected disability rated 30% or more; (2) they are traveling for treatment of a service-connected disability; (3) they receive a VA pension; (4) their income does not exceed the maximum annual VA pension rate; or (5) they are traveling for a scheduled compensation or pension examination.

⁸⁸ Veterans Administration, "Transportation of Claimants and Beneficiaries," final regulations, 52 FR 7575-01, March 12, 1987. These regulations became effective on April 13, 1987.

⁸⁹ Ibid.

The FY2008 Appropriations Act (P.L. 110-161) provided funding for VA to increase the beneficiary travel mileage reimbursement rate from 11 cents per mile to 28.5 cents per mile. The increase went into effect on February 1, 2008. While increasing the payment, VA, as mandated by law, also increased proportionately the deductible amounts applied to certain mileage reimbursements. The new deductibles were \$7.77 for a one way trip, \$15.54 for a round trip, with a maximum of \$46.62 per calendar month. However, these deductibles could have been waived if they cause a financial hardship to the veteran.

The final MILCON-VA Appropriations Act of 2009 (P.L. 110-329) provided an additional \$133 million to increase the mileage reimbursement rate to 41.5 cents a mile and included an administrative provision to freeze the deductible at the FY2008 levels (i.e. \$7.77 for a one way trip, \$15.54 for a round trip, with a maximum of \$46.62 per calendar month).

The Veterans' Mental Health and Other Care Improvements Act of 2008 (S. 2162, P.L. 110-387), which was signed into law on October 10, 2008, contained a provision that required the VA to raise its current reimbursement rate to conform with the General Services Administration's (GSA) rate at which federal employees are reimbursed when using private automobiles for official business. The provision also amended the law that allowed the VA to raise or lower the deductible for reimbursements in proportion to a change in the mileage rate. The VA is no longer able to increase the deductible rate unless new deductible rates are mandated by Congress. It also restored the deductible amounts for the beneficiary travel reimbursement program to those in effect prior to February 1, 2008, when VA increased the deductible rate (i.e. \$3 for a one way trip, \$6 for a round trip, with a maximum of \$18 per calendar month).

The reports accompanying the MILCON-VA Appropriations Act of 2010 (H.Rept. 111-188 and S.Rept. 111-40) state that VA should continue to provide beneficiary travel reimbursements at 41.5 cents a mile.⁹⁰

⁹⁰ Current GSA rates are as follows: if government-owned vehicle is not available, the rate is \$0.55; if a government-owned vehicle is available, the rate is \$0.285; see <http://www.gsa.gov/mileage>.

Table 7.VHA Appropriations by Account, FY2009-FY2010 and Advance Appropriations, FY2011

(\$ in thousands)

Account	FY2009 Enacted	FY2010 Request	House (H.R. 3082)		Senate (H.R. 3082)		Enacted (P.L. 111-117)	
			FY2010	FY2011	FY2010	FY2011	FY2010	FY2011
Medical Services	\$30,969,903	\$34,704,500	\$34,705,500	—	\$34,705,250	—	\$34,707,500	—
<i>Subtotal Medical Services</i>	<i>30,969,903</i>	<i>34,704,500</i>	<i>34,705,500</i>	—	<i>34,705,250</i>	—	<i>34,707,500</i>	—
Medical Support and Compliance (Previously Medical Administration)	4,450,000	5,100,000	4,896,500	—	5,100,000	—	4,930,000	—
<i>Subtotal Medical Support and Compliance (Previously Medical Administration)</i>	<i>4,450,000</i>	<i>5,100,000</i>	<i>4,896,500</i>	—	<i>5,100,000</i>	—	<i>4,930,000</i>	—
Medical Facilities	5,029,000	4,693,000	4,893,000	—	4,849,883	—	4,859,000	—
American Recovery and Reinvestment Act, 2009 (P.L. 111-5)	1,000,000	—	—	—	—	—	—	—
<i>Subtotal Medical Facilities</i>	<i>6,029,000</i>	<i>4,693,000</i>	<i>4,893,000</i>	—	<i>4,849,883</i>	—	<i>4,859,000</i>	—
Medical and Prosthetic Research	510,000	580,000	580,000	—	580,000	—	581,000	—
<i>Subtotal Medical and Prosthetic Research</i>	<i>510,000</i>	<i>580,000</i>	<i>580,000</i>	—	<i>580,000</i>	—	<i>581,000</i>	—
Total VHA appropriations (without collections)	41,958,903	45,077,500	45,075,000	—	45,235,133	—	45,077,500	—
Medical care cost collections (MCCF)	2,544,000	2,954,000	2,954,000	—	2,954,000	—	2,954,000	—

Account	FY2009 Enacted	FY2010 Request	House (H.R. 3082)		Senate (H.R. 3082)		Enacted (P.L. 111-117)	
			FY2010	FY2011	FY2010	FY2011	FY2010	FY2011
Total VHA appropriations (with collections)	\$44,502,903	\$48,031,500	\$48,029,000	—	\$48,189,133	—	\$48,031,500	—
Memorandum: Advance Appropriations								
Medical Services	—	—	—	\$37,136,000	—	\$37,136,000	—	\$37,136,000
Subtotal Medical Support and Compliance (Previously Medical Administration)	—	—	—	5,307,000	—	5,307,000	—	5,307,000
Medical Facilities	—	—	—	5,740,000	—	5,740,000	—	5,740,000
Total VHA advance appropriations (without collections)^a	—	—	—	\$48,183,000	—	\$48,183,000	—	\$48,183,000

Sources: Table prepared by Congressional Research Service, based on H.Rept. 110-775; S.Rept. 110-428; *Congressional Record*, vol.154, (September 24, 2008), pp. H9868-H9869, H.Rept. 111-188, S.Rept. 111-40, *Congressional Record*, vol.155, (July 10, 2009), pp. H7983-H7987, *Congressional Record*, vol. 155 (November 18, 2009), pp. S11500-11508, and Division E of P.L. 111-117.

- a. The House and Senate Military Construction and Veterans Affairs Appropriations bills for FY 2010, and Division E of the Consolidated Appropriations Act 2010 (Military Construction and Veterans Affairs Appropriations Act, 2010) provided budget authority for FY2011 for the following accounts: medical services, medical support and compliance, and medical facilities. Under current budget scoring guidelines new budget authority for an advance appropriation is scored in the fiscal year in which the funds become available for obligation. Therefore, in this table the budget authority is recorded in the FY2011 column.

Appendix A. VA Priority Groups and Their Eligibility Criteria

Table A-1. VA Priority Groups and Their Eligibility Criteria

Priority Group 1

Veterans with service-connected disabilities rated 50% or more disabling

Priority Group 2

Veterans with service-connected disabilities rated 30% or 40% disabling

Priority Group 3

Veterans who are former POWs

Veterans awarded the Purple Heart^a

Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty

Veterans with service-connected disabilities rated 10% or 20% disabling

Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, “benefits for individuals disabled by treatment or vocational rehabilitation”

Priority Group 4

Veterans who are receiving aid and attendance or housebound benefits

Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5

Non-service-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA means test thresholds

Veterans receiving VA pension benefits

Veterans eligible for Medicaid benefits

Priority Group 6

Compensable 0% service-connected veterans

World War I veterans

Mexican Border War veterans

Veterans solely seeking care for disorders associated with

—exposure to herbicides while serving in Vietnam; or

—ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or

—for disorders associated with service in the Gulf War; or

—for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998 as follows:

- Veterans discharged from active duty on or after January 28, 2003, who were enrolled as of January 28, 2008 and veterans who apply for enrollment after January 28, 2008, for 5 years post discharge

- Veterans discharged from active duty before January 28, 2003, who apply for enrollment after January 28, 2008, until January 27, 2011

Priority Group 7

Veterans who agree to pay specified copayments with income and/or net worth *above* the VA means test threshold and income *below* the VA national geographic income thresholds

Priority Group 8

Veterans who agree to pay specified copayments with income and/or net worth *above* the VA means test threshold and the VA national geographic threshold

Subpriority a: Noncompensable 0% service-connected and enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status

Subpriority b: Noncompensable 0% service-connected and enrolled on or after June 15, 2009 whose income exceeds the current VA means test threshold or VA national geographic income thresholds by 10% or less

Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status

Subpriority d: Nonservice-connected veterans enrolled on or after June 15, 2009 whose income exceeds the current VA means test threshold or VA national geographic income thresholds by 10% or less

Subpriority e: Noncompensable 0% service-connected veterans not meeting the above criteria

Subpriority g: Nonservice-connected veterans not meeting the above criteria

Source: Department of Veterans Affairs

Notes: Service-connected disability means with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval or air service.

- a. Veterans in receipt of a Purple Heart are in Priority Group 3. This change occurred with the enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) on Nov.30, 1999.

Appendix B. Copayments for Health Care Services: 2010

Table B-1. Copayments for Health Care Services: 2010

	Inpatient care (\$10/day + \$1068 for first 90 days and \$534 after 90 days—based on 365-day period)	Outpatient care (\$15 Primary Care; \$50 Specialty Care; \$0 for x-rays, lab, immunizations, etc.)	Outpatient medication (\$8 per 30-day supply; Priority Groups 2-6 calendar year cap - \$960)	Long-term care services (Institutional nursing home care units, respite care, geriatric evaluation - \$0-97 per day. Non-institutional respite care, geriatric evaluation, adult day healthcare - \$15 per day; domiciliary care - \$5 per day)
Priority Group 1 (service-connected disabilities rated 50% or more disabling)	NO	NO	NO	NO
Priority Groups 2 and 3 (Veterans with service-connected disabilities rated 10% - 40% disabling) ^a	NO	NO	YES	NO
Priority Group 4 Copay rules apply if placed from lower priority group based on VHA catastrophic disability determination	NO	NO	NO	NO
Priority Group 5 ^b	NO	NO	YES	YES
Priority Group 6 ^c	NO	NO	NO	NO
Priority Group 7 ^d	YES	YES	YES	YES
Priority Group 8 ^e	YES	YES	YES	YES

Source: Table prepared by CRS based on information from the Department of Veterans Affairs.

- No medication copayments if medication is for a service-connected disability. Former POWs are exempt from all medications copayments.
- No medication or long-term care copayments if veteran is in receipt of VA pension or has an income below applicable pension threshold.
- Priority Group 6 are veterans claiming exposure to Agent Orange; veterans claiming exposure to environmental contaminants; veterans exposed to ionizing radiation; combat veterans within five years of discharge from the military; veterans who participated in Project 112/SHAD; veterans claiming military sexual trauma; and veterans with head and neck cancer who received nasopharyngeal radium treatment while in the military are subject to copayments when their treatment or medication is not related to their

exposure or experience. The initial registry examination and follow-up visits to receive results of the examination are not billed to the health insurance carrier and are not subject to copayments. However, care provided that is not related to exposure, if it is nonservice-connected, will be billed to the insurance carrier and copayments can apply.

- d. Priority Group 7a and 7c veterans have income above the VA Means Test threshold but below the Geographic Means Test threshold and are responsible for 20% of the inpatient copayment and 20% of the inpatient per diem copayment. The Geographic Means Test copayment reduction does not apply to outpatient and medication copayment, and veterans will be assessed the full applicable copayment charges.
- e. Priority Group 8a and 8c veterans have income above the VA Means Test threshold and above the Geographic Means Test threshold. Veterans enrolled in this priority group are responsible for the full inpatient copayment and the inpatient per diem copayment for care of their nonservice-connected conditions. Veterans in this priority group are also responsible for outpatient and medication copayments for care of their nonservice-connected conditions.

OEI/OIF Combat Veterans Enhanced Eligibility for Health Care Benefits: Combat veterans discharged from active duty on or after January 28, 2003 are eligible for enrollment in Priority Group 6 for five years following discharge unless eligible for a higher enrollment priority. Combat veterans discharged from active duty before January 28, 2003, who apply for enrollment on or after January 28, 2008, are eligible for enrollment in Priority Group 6 until January 27, 2011. After the special eligibility period ends, these veterans will be reassigned to the appropriate priority group and will be subject to copayments if applicable. Copayments are applicable for Priority Group 6 combat veteran enrollees for care related to a condition that is congenital or developmental (e.g., scoliosis) that existed before military service (unless aggravated by combat service) or has a specific etiology that began after military service, such as a common cold, etc.

Appendix C. Financial Income Thresholds for VA Health Care Benefits, Calendar Year 2010

Veterans with—	Free VA prescriptions and travel benefits for veterans with incomes of—	Free VA Health Care for veterans with incomes of—
No dependents	\$11,830 or less	\$29,402 or less
1 dependent	\$15,493 or less	\$35,284 or less
2 dependents	\$17,513 or less	\$37,304 or less
3 dependents	\$19,533 or less	\$39,324 or less
4 dependents	\$21,553 or less	\$41,344 or less
For each additional dependent, add:	\$2,020	\$2,020

Source: Department of Veterans Affairs.

Appendix D. 10% Increase to Financial Income Thresholds for VA Health Care Enrollment, in Priority Group 8, Calendar Year 2010

Veterans with—	Enrollment in the VA Health Care System with required copayments for veterans with 0% service-connected ratings and nonservice-connected veterans with incomes of—
No dependents	\$32,342
1 dependent	\$38,812
2 dependents	\$41,034
3 dependents	\$43,256
4 dependents	\$45,478
For each additional dependent, add:	\$2,222

Source: Department of Veterans Affairs.

Author Information

Sidath Viranga Panangala
Specialist in Veterans Policy

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.